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REPORT 99-94
Part 2

INDIAN HEALTH CARE AMENDMENTS OF 1985

MAY 23, 1985.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany H.R. 1426, which on March 5, 1985, was referred jointly to the Committee on Interior and Insular Affairs and the Committee on Energy and Commerce]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce to whom was referred the bill (H.R. 1426) to reauthorize and amend the Indian Health Care Improvement Act, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 2, line 10, strike out "Section" and insert in lieu thereof "Subsection".

Page 3, line 13, insert "(a)" after "103.".

Page 3, line 18, insert "and, subject to available appropriations, Native Hawaiians" after "Indians".

Page 4, line 3, insert "and, subject to available appropriations, Native Hawaiians" after "Indians".

Page 5, insert after line 3 the following new subsection:

(b) Section 338G of the Public Health Service Act (42 U.S.C. 254r) is repealed.

Page 5, insert after line 24 the following new section:

51-006 O

AUTHORIZATION FREEZE

SEC. 106. Notwithstanding any other provision of this title, the total amount authorized to be appropriated under this title may not exceed—

(1) $6,490,000 for fiscal year 1986,
(2) $6,690,000 for fiscal year 1987,
(3) $6,920,000 for fiscal year 1988, and
(4) $7,170,000 for fiscal year 1989.".

Page 6, line 6, strike out "210" and insert in lieu thereof "201".

Page 6, line 16, strike out "Unted" and insert in lieu thereof "United".

Page 6, line 26, strike out "of the Service".

Page 7, line 21, insert "tribe or" after "allocated to a".

Page 7, line 23, strike out "not more than 15 per centum" and insert in lieu thereof "a reasonable proportion".

Page 7, line 23, strike out "shall" and insert in lieu thereof "may".

Page 8, line 1, insert "(A)" after "(3)" and strike out lines 6 through 10 and insert in lieu thereof the following subparagraph:

"(B) Funds appropriated under this section may be allocated on a tribe or service unit basis. If allocated on a service unit basis, such funds shall be used by each service unit to raise the deficiency level of each tribe served by such service unit. Apportionment of a tribe or service unit's allocation of funds among the health service responsibilities listed in paragraph (1) shall be determined by the Service and the affected Indian tribe or tribes.

Page 8, beginning in line 2, strike out "service units" and insert in lieu thereof "tribes".

Page 8, line 5, strike out "service units" and insert in lieu thereof "tribes".

Page 8, line 14, insert "tribe or" after "for each".

Page 8, line 15, insert "service" before "units".

Page 8, line 19, strike out "service unit" and insert in lieu thereof "tribe".

Page 8, line 20, strike out "service units" and insert in lieu thereof "tribes".

Page 8, line 22, strike out "service units" and insert in lieu thereof "tribes".

Page 8, line 24, strike out "service units" and insert in lieu thereof "tribes".

Page 8, line 25, strike out "and".

Page 9, line 5, strike out "or comparable entity" and insert in lieu thereof "tribe".

Page 9, line 7, strike out the period following "unit" and insert in lieu thereof "and each tribe; and".

Page 9, insert after line 7, the following new subparagraph:

"(C) an evaluation of—

"(i) the preventive health, health protection, and health promotion needs of Indians identified in tribal specific health plans;

"(ii) the preventive health, health protection, and health promotion services necessary to meet such needs;

"(iii) the resources which would be required to enable the Service to provide such services; and

"(iv) the resources currently available to the Service which could be used to provide such services.

Page 9, line 18 and 19, strike out "the service unit through which such tribe receives health services." and insert in lieu thereof "such tribe.".

Page 10, line 19, strike out "of" and insert in lieu thereof "on".

Page 13, line 1, strike out "warrent" and insert in lieu thereof "warrant".

Page 13, line 17, strike out the close quotation mark and the period following and insert after that line the following:

(d) By no later than January 1, 1989, the Secretary shall report to Congress on the operation of the Fund. Such report shall include—

"(1) the number and nature of disasters and catastrophic illnesses for which reimbursement was sought;

"(2) the costs associated with such disasters or illnesses;

"(3) the amounts reimbursed by the Fund in connection with such disasters and illnesses;

"(4) the effect of the Fund on the ability of service units to meet the health needs of their service populations; and

"(5) the Secretary's recommendations regarding the future operation of the Fund.".

Page 13, line 19, insert "as amended by section 202 of this Act" after "Title II" and insert "further" after "is".

Page 14, line 2, strike out "and" and insert in lieu thereof "or".

Page 14, line 11, strike out "and" and insert in lieu thereof "or".

Page 14, insert after line 12, the following:

PREVENTIVE HEALTH, HEALTH PROTECTION, AND HEALTH PROMOTION

SEC. 204. Title II, as amended by sections 202 and 203 of this Act, is further amended by adding at the end the following new section:

"PREVENTIVE HEALTH, HEALTH PROTECTION, AND HEALTH PROMOTION

"SEC. 204. (a) The Congress finds that—

"(1) preventive health, health protection, and health promotion services will—

"(A) improve the health and well-being of Indians; and

"(B) reduce the expenses for medical care of Indians;

"(2) preventive health, health protection, and health promotion services should be provided by the coordi-

nated efforts of Federal, State, local, and tribal governments; and

"(3) in addition to the provision of primary health care, the Service should provide preventive health, health protection, and health promotion services to Indians.

"(b) The Secretary, acting through the Service, shall—

"(1) require, by regulation, that each Indian tribe include within any tribal specific health plan submitted to the Secretary—

"(A) an identification of the preventive health, health protection and health promotion needs of such tribe; and

"(B) a comprehensive plan for providing such services to such tribe;

"(2) develop from tribal specific health plans a comprehensive plan for the provision by the Service of preventive health, health protection, and health promotion services to Indians;

"(3) establish a schedule for the provision of such services by the Service; and

"(4) provide such services to Indians in accordance with such comprehensive plan and schedule.".

Page 21, line 19, strike out "or tribe or family" and insert in lieu thereof ", tribe, or family".

Page 23, line 19, strike out "or any" and insert in lieu thereof "of any".

Page 25, line 13, strike out "a ruling" and insert in lieu thereof "the ruling".

Page 25, line 22, strike out "facility" and insert in lieu thereof "facilities".

Page 27, line 13, strike out "$3,000,000" and insert in lieu thereof "$1,500,000".

Page 27, line 14, strike out "$3,500,000" and insert in lieu thereof "$2,000,000".

Page 27, line 15, strike out "$4,000,000" and insert in lieu thereof "$2,500,000".

Page 27, line 16, strike out "$4,500,000" and insert in lieu thereof "$2,000,000".

Page 27, insert after line 17 the following:

MEDICAID PROVISIONS

SEC. 402. (a) Section 1911 of the Social Security Act is amended by striking out "or skilled nursing facility" each place it appears and inserting in lieu thereof in each instance "skilled nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan".

(b) Section 1911 of the Social Security Act is amended by adding at the end thereof the following new subsections:

"(c) The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Indian

Health Service facilities to Indians who are eligible for medical assistance under the State plan.

"(d) Notwithstanding any other provision of law, payments to which any facility of the Indian Health Service (including a hospital, intermediate care facility, skilled nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) is entitled under a State plan approved under this title by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. In making payments from such fund, the Secretary shall ensure that each service unit of the Indian Health Service receives at least 50 percent of the amounts to which the facilities of the Indian Health Service, for which such service unit makes collections, are entitled by reason of this section, if such amount is necessary for the purpose of making improvements in such facilities in order to achieve compliance with the conditions and requirements of this title. This subsection shall cease to apply when the Secretary determines and certifies that substantially all of the health facilities of such Service in the United States are in compliance with such conditions and requirements.".

(c) Subsections (b) and (c) of section 402 of the Indian Health Care Improvement Act (42 U.S.C. 1396j, note) are repealed.

(d) The amendments made by this section shall apply to health care services performed on or after the date of the enactment of this Act.

STUDY OF BARRIERS TO MEDICAID PARTICIPATION

SEC. 403. Title IV is amended by adding at the end thereof the following new section:

"STUDY OF BARRIERS TO MEDICAID PARTICIPATION

"SEC. 405. (a) The Secretary shall, in consultation with Indian tribes and tribal organizations, conduct a study of any barriers which may prevent Indians from receiving medical assistance under State plans approved under title XIX of the Social Security Act.

"(b) By no later than the date which is one year after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress a report on the study conducted under subsection (a). Such report shall include—

"(1) recommendations for legislation which—

"(A) would remove any barriers identified in such study which prevent Indians from receiving

medical assistance under plans described in subsection (a) and,

"(B) would encourage participation by Indians in such plans; and

"(2) estimates, by service unit, of—

"(A) the number of Indians potentially eligible for medical assistance under such plans, and

"(B) the number of Indians receiving medical assistance under such plans.".

Page 28, line 17, strike out "OF" the second time it appears and insert in lieu thereof "OR".

Page 30, line 6, strike out "met" and insert in lieu thereof "meet".

Page 30, line 9, strike out "provisions of," and insert in lieu thereof "provision of".

Page 31, line 22, strike out "center" and insert in lieu thereof "centers".

Page 31, line 26, strike out "Indian" and insert in lieu thereof "Indians".

Page 33, line 17, strike out "It" and insert in lieu thereof "If".

Page 36, line 15, strike out "$12,000,000" and insert in lieu thereof "$9,800,000".

Page 36, line 16, strike out "$13,200,000" and insert in lieu thereof "$10,090,000".

Page 36, line 17, strike out "$14,400,000" and insert in lieu thereof "$10,440,000".

Page 36, line 18, strike out "$15,800,000" and insert in lieu thereof "$10,810,000".

Page 36, strike out line 20 and insert in lieu thereof the following:

ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE

Page 36, line 21, strike out "(a)" after "601.".

Page 36, strike out line 22 and all that follows through line 5 on page 40 and insert in lieu thereof the following:

"TITLE VI—ORGANIZATION IMPROVEMENTS

"ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE

"SEC. 601. (a) In order to more effectively and efficiently carry our the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department of Health and Human Services the Indian Health Service. The Indian Health Service shall be administered by a Director, who shall be appointed by the President, by and with the advice and consent of the Senate. The Director of the Indian Health Service shall report to the Secretary through the Assistant Secretary for Health, of the Depart-

ment of Health and Human Services, and shall not report to, or be under the supervision of, any other officer or employee of such Department.

"(b) The Indian Health Service shall be an agency within the Public Health Service of the Department of Health and Human Services, and shall not be an office, component, or unit of any other agency of the Department.

"(c) The Secretary shall carry out through the Director of the Indian Health Service—

"(1) all functions which were, on the day before the date of enantment of the Indian Health Care Amendments of 1985, carried out by or under the direction of the individual serving as Director of the Indian Health Service on each day;

"(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and the provision and utilization of, health services for Indians; and

"(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including (but not limited to) programs under—

"(A) this Act;

"(B) the Act of November 2, 1921 (25 U.S.C. 13);

"(C) the Act of August 5, 1954 (68 Stat. 674);

"(D) the Act of August 16, 1957 (71 Stat. 370); and

"(E) the Indian Self-Determination and Education Assistance Act (Public Law 93–638).

"(d)(1) Notwithstanding any other provision of law, the Secretary may not reorganize, alter, or discontinue the Indian Health Service or allocate or reallocate any function which this section specifies shall be performed by the Director of the Indian Health Service or by the Secretary of Health and Human Services through the Director of the Indian Health Service.

"(2) Paragraph (1) shall not apply to any action taken by the Director of the Indian Health Service which the Director of the Indian Health Service determines to be appropriate.

"(e)(1) The Director of the Indian Health Service shall have the authority—

"(A) except to the extent provided in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

"(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

"(C) to manage, expend, and obligate all funds appropriated for the Service.

"(2) The Provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), but not the provisions of section 2 of Public Law 96–135 (25 U.S.C. 472a), shall apply

to personnel actions taken with respect to positions within the Service.

"(3) The authority of the Director of the Indian Health Service to enter into contracts under this subsection shall be to such extent or in such amounts as are provided in apprropriation Acts.".

Redesignate the succeeding section according.

Page 40, line 17, strike out the choice quotation marks and the period following and insert after that line the following:

(c) Notwithstanding any other provisions of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

"(d) The Secretary by not later than September 30, 1988, shall provide—

"(1) all tribes or tribal organizations providing health services in California under a contract with the Service under the Indian Self-Determination Act, and

"(2) all urban Indian organizations providing health services in California under a contract with the Service under section 503 of this Act,

with automated management information systems which meet the management information needs of each such tribe or organization.".

(b) All personnel, records, equipment, facilities, and interests in property that are administered by the Indian Health Service on the day before the date on which the amendments made by this section take effect shall be transferred to the Indian Health Service established by the amendment made by subsection (a) of this section.

(c) The Secretary of Health and Human Services may waive the application of the Indian preference laws on a case-by-case for any temporary transfer which is necessary in order to implement the amendments made by subsection (a) of this section during the nine month period beginning on the date on which the amendments made by this section take effect.

(d) The amendments made by this section shall take effect nine months from the date of enactment of this Act.

Page 41, line 11, strike out "cost" and insert in lieu thereof "costs".

Page 44, line 24, strike out "is" and insert in lieu thereof "are".

Page 46, line 11, strike out "Act" and insert in lieu thereof "section".

Page 48, line 3, strike out "interest" and insert in lieu thereof "interests".

Page 49, strike out line 25 and insert in lieu thereof the following:

services to such Indians. In making such alternative arrangements for such Indians, the Service may—

"(1) provide services directly to some or all of such Indians through its own facilities,

"(2) purchase services for some or all of such Indians on a contract basis,

"(3) contract with a qualified organization representing some or all of such Indians for the provision of services under the terms of the third proviso of the first paragraph under the heading "Secretary" in the division relating to general provisions of the Act of April 30, 1908 (35 Stat. 71, chapter 153; 25 U.S.C. 47), popularly known as the Buy Indian Act, or

"(4) make other effective arrangements for the delivery of health care services to such Indians.

"(c) Nothing in this section shall be con-

Page 54, beginning on line 18, strike out "under a plan adopted under subsection (d) of this section".

Page 54, beginning on line 21, strike out "sections 1346(b) and 2671 and the following" and insert in lieu thereof "the provisions".

Page 55, line 3, insert "(a)" after "SEC. 714.".

Page 55, line 9, insert "other" after "such".

Page 55, insert after line 13 the following new subsection:

"(b) The Service may not offset or limit the amount of funds obligated to any entity udner contract with the Service because of the use of funds, other than funds appropriated to the Indian Health Service, by such entity for the purposes described in paragraphs (1) through (3) of subsection (a).

Page 55, insert after line 25 the following new subsection:

"(b) The Secretary shall report to Congress on January 1 of each year beginning after fiscal year 1986 on the progress that has been made toward achieving the objectives described in subsection (a).

Page 56, insert after line 8 the following:

INDIAN HEALTH SERVICE AND VETERANS' ADMINISTRATION HEALTH FACILITIES AND SERVICES SHARING

SEC. 710. Title VII, as amended by sections 707, 708, 709 and 710 of this Act, is further amended by adding at the end thereof the following new sections:

"INDIAN HEALTH SERVICE AND VETERANS' ADMINISTRATION HEALTH FACILITIES AND SERVICES SHARING

"SEC. 717. (a) The Secretary shall examine the feasibility of entering into an arrangement for the sharing of medical facilities and services between the Indian Health Service and the Veterans' Administration and shall, in accordance with subsection (b), prepare a report on the feasibility of such an arrangement and submit such report to the Congress not later than September 30, 1986.

"(b) The Secretary may not make any recommendation under subsection (a) nor take any action under subchapter IV of part VI of title 38, United States Code which would impair—

"(1) the priority access of any Indian to health care services provided through the Indian Health Service;

"(2) the quality of health care services provided to any Indian through the Indian Health Service;

"(3) the priority access of any veteran to health care services provided by the Veterans' Administration;

"(4) the quality of health care services provided to any veteran by the Veterans' Administration;

"(5) the eligibility of any Indian person to receive health services through the Indian Health Service; or

"(6) the eligibility of any Indian person who is a Veteran, to receive health services through the Veterans' Administration.

"NAVAJO ALCOHOL REHABILITATION DEMONSTRATION PROGRAM

"SEC. 718. (a) The Secretary shall make grants to the Navajo tribe to establish a demonstration program in the city of Gallup, New Mexico, to rehabilitate adult Navajo Indians suffering from alcoholism or alcohol abuse.

"(b) The Secretary, acting through the National Institute on Alcohol Abuse and Alcoholism, shall evaluate the program established under subsection (a) and submit a report on such evaluation to the appropriate Committees of Congress by January 1, 1989.

"(c)(1) There is authorized to be appropriated for the purposes of this section $400,000 for each of the fiscal years 1986, 1987, and 1988.

"(2) Not more than 10 percent of the funds appropriated under paragraph (1) for any fiscal year may be used for administrative purposes.

"STUDY OF HEALTH CARE NEEDS OF NATIVE HAWAIIANS AND OTHER NATIVE PACIFIC ISLANDERS

"SEC. 719. (a)(1) The Secretary shall conduct a study of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders.

"(2) In conducting the study required under paragraph (1), the Secretary shall consult with the Commissioner of the Administration for Native Americans, the Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, the Director of the Indian Health Service, leaders in the field of health care, and representatives of Native Hawaiians and other Native American Pacific Islanders.

"(b) By no later than the date that is 1 year after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress a report on the study conducted under subsection (a). Such report shall include—

"(1) an assessment of the access of, and barriers to, Native Hawaiians and other Native American Pacific Islanders in receiving physical and mental health care services,

"(2) an assessment of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders, and

"(3) specific recommendations for the development of a national strategy to address such needs."

Page 56, line 10, strike out, "710" and insert "711" in lieu thereof.

Page 56, line 24, strike out the close quotation mark and the period following and add after that line the following:

"(k) 'Native Hawaiian' means any individual who has any ancestors that were natives, prior to 1778, of the area that now comprises the State of Hawaii.

"(l) 'Native American Pacific Islander' means—

"(1) any Native Hawaiian,

"(2) any of the indigenous people residing in Guan, American Samoa, the Trust Territory of the Pacific Islands, or the Northern Mariana Islands; or

"(3) any individual whose direct ancestors are from Guam, American Samoa, the Trust Territory of the Pacific Islands, or the Northern Mariana Islands.".

Page 57, line 2, strike out "711" and insert "712" in lieu thereof.

CONTENTS

Purpose and Summary

The Committee bill revises and extends, through FY 1989, the Indian Health Care Improvement Act. The central purpose of the Act is to raise the health status of the American Indian and Native Alaska people to a parity with that of the general population. The authorization of appropriations contained in the Act expired on October 1, 1984.

In the 98th Congress, the Committee ordered reported a similar bill, the Indian Health Care Amendments of 1984, H.R. 4567 (H. Rept. 98–763, Part 2), which would have revised and extended the Indian Health Care Improvement Act through FY 1987. The conference report on this legislation, S. 2166 (H. Rept. 98–1126), was

approved by both the House and the Senate. However, on October 19, 1985, the President announced his decision to withhold approval of S. 2166.

The Committee bill does not contain either of the provisions that the President, in his memorandum of disapproval of S. 2166, cited as "especially troublesome." The Committee bill reauthorizes health manpower and urban Indian health programs, and it makes improvements in existing programs for health services and health and sanitation facilities construction.

In fashioning this reauthorization, the Committee has adopted a budget "freeze" approach. Under the Committee bill, FY 1986 authorizations for all of the programs encompassed by the Indian Health Care Improvement Act total $74 million, below the $78 million appropriated for these various activities under the Act in FY 1985. While this legislation does not affect all appropriations for Indian health (these totalled $865.0 million in FY 1985), the Committee believes that the bill strikes a reasonable balance between the health needs of the Indian people and Federal budgetry constraints.

Background and Need for the Legislation

The Indian Health Care Improvement Act, P.L. 94–437, was enacted in 1976. It is one of several statutory authorities on which appropriations for Indian health are based. (The other major authorities are the Snyder Act, 25 U.S.C. Sec. 13; the Transfer Act, 42 U.S.C. Sec. 2001 et seq.; and the Indian Self-Determination Act, 25 U.S.C. 450f et seq.).

The Indian Health Care Improvement Act was enacted in response to documented deficiencies in the health status of the Indian people. The legislation authorized additional funds for Indian health care, in part to reduce unmet needs under existing programs, and in part to establish specific new initiatives, such as health manpower training and urban health projects. A major purpose of the 1976 Act was to raise the health status of the American Indian and Alaska Native people, over a seven year period, to a level comparable to that of the general U.S. population. In 1980, the Congress revised and extended the legislation through September 30, 1984.

Despite some gains since 1976, the health status of Indians remains poorer than that of the general U.S. population. American Indians and Alaska Natives have higher mortality rates than are experienced by the general U.S. population. In 1980, the age-adjusted mortality rate (from all causes) for Indians and Alaska Natives was about 10 percent higher than that for the general U.S. population.

Indians die younger than much of the U.S. population. Of all deaths in the general U.S. population in 1981, only 5.5 percent occurred in those under age 25, and only 32.3 percent occurred in those under age 65. Among American Indians and Alaska Natives, the corresponding percentages were 19 percent in the under 25 age group and 61.6 percent in the under 65 age group.

Indians are more likely than the rest of the U.S. population to die of tuberculosis, chronic liver disease and cirrhosis, accidents, di-

abetes, pneumonia and influenza, homicide, and suicide. The age-adjusted tuberculosis death rate for American Indians and Alaska Natives in 1980 was six times greater then that for the general U.S. population. In the same year, the age-adjusted Indian death rate from chronic liver disease and cirrhosis was three and one half times greater than that for the general population.

The causes of this differential in health status are numerous. Among the major contributing factors are the lack of adequate water supply and sewage disposal systems; the high incidence of poverty and unemployment among the Indian population; alcohol and other substance abuse; a lack of access to health care practitioners and facilities; and a shortage of financial resources to meet identified health needs.

In the view of the Committee, the Federal Government has a legal and moral responsibility to assure that the health status of the Indian people is at parity with that of the general U.S. population. The purpose of the Indian Health Care Improvement Act, as amended by the Committee, is to discharge that responsibility.

TITLE I. INDIAN HEALTH MANPOWER

Title I of the Indian Health Care Improvement Act contains a number of different programs designed to increase the number of health professionals serving Indians: recruitment, preparatory scholarship, extern, and continuing education programs. In addition, section 338G of the Public Health Service Act authorizes an Indian health scholarship program to develop physicians, osteopaths, dentists, veterinarians, nurses. optometrists, podiatrists, pharmacists, clinical psychologists, public health personnel, and allied health professionals to deliver services to Indians.

Under the Committee bill, these important programs would be reauthorized through FY 1989. The proposed authorizations for all the Indian health manpower programs in Title I total $6.49 million in FY 1986 (the same level as FY 1985 appropriations), $6.69 million in FY 1987, $6.92 million in FY 1988, and $7.17 million in FY 1989. Allocation of authorized funds among the difference manpower program under Title I would be left to the discretion of the Committee on Appropriations.

The Committee bill would revise the authorization for the Indian health scholarship program, currently found at section 338G of the Public Health Service Act, and recodify it at section 104 of the Indian Health Care Improvement Act. Under current law, applicants who are Indians are to be accorded priority in the award of scholarships. In view of the continuing shortage of Indian health professionals and the limited scholarship resources available, the Committee bill provides that only Indians are eligible to receive scholarships.

The Committee bill also provides that, subject to available appropriations, Native Hawaiians may receive health professions scholarships, and that the distribution of such scholarships among the health professions should be based on the relative needs of Native Hawaiians for additional services in the professions. The purpose of this provision is to increase the number of Native Hawaiian health professionals and thereby to increase the accessibility of qualified

practitioners to the Native Hawaiian population, partic- ularly in rural areas with a shortage of health services.

TITLE II. HEALTH SERVICES

Indian Health Care Improvement Fund

Title II of the Indian Health Care Improvement Act currently authorizes the Indian Health Service (IHS to provide health care services for the purpose of eliminating backlogs in Indian health services and to fill known but unmet health needs. A total of $82.4 million was authorized to be appropriated in FY 1984 for a number of different categories of services, including patient care (direct and indirect), field health, dental care, mental health, alcoholism treatment and control, and maintenance and repair. These funds are designated as additional resources, above and beyond the regular or "base" IHS appropriations, for the purpose of raising the health status of Indians. At least 1 percent of the funds appropriated in each of these categories is to be spent on research.

The available evidence indicates that, despite some important gains, the health status of the Indian people continues to lag behind that of the general population. In addition, it is abundantly clear that, within the Indian population, inequities in IHS funding allocations have left some tribes with relatively fewer health resources than others.

Table I compares, on a per eligible Indian basis, the allocation of funding for clinical services in FY 1985 among the 12 IHS area offices, through which the IHS programs are administered. The average amount spent for hospital, physician, and other clinical care in FY 1985 was $675.85. However, per capita spending varied widely from area to area, with the lowest spending in California ($298.63 per eligible Indian) and the higheast in the Alaska area ($1,346.53 per eligible Indian).

TABLE. I.—FISCAL YEAR 1985 IHS SPENDING FOR CLINICAL SERVICES, BY AREA

Area	Service population	Clinical services funding	Per capita allocation
Aberdeen	72,184	$58,601,000	$811.83
Albuquerque	52,132	42,440,000	814.09
Anchorage	72,583	97,735,000	1,346.53
Bemidji	47,951	30,567,000	637.46
Billings	41,115	41,324,000	1,005.08
California	72,241	21,573,000	298.63
Navajo	165,597	88,756,000	535.98
Oklahoma	191,903	79,466,000	414.09
Phoenix	83,536	68,178,000	816.15
Portland	84,667	37,973,000	448.50
Tucson	18,168	12,427,000	684.00
Nashville (USET)	29,056	26,521,000	912.75
Total	931,133	629,304,000	675.85

Source: IHS Resources Management Branch and IHS population statistics staff.

There is also wide variation among the eligible tribes with respect to IHS health spending, both within and among the different IHS areas. The IHS has developed a methodology for ranking tribes based upon their "deficiency levels." This is essentially a

measure, expressed as a percentage, of the additional dollar resources that a tribe would need in order to purchase the facilities and staff to meet its projected demand for impatient and outpatient services. For example, a trible which has only half the funds it would need to meet its projected demand for services would be considered 50 percent deficient (additional resources required divided by total resources required), and would fall into the 40 to 60 percent level of deficiency. Table II sets forth the IHS ranking of tribes, by deficiency level, as of April, 1984. More than half the tribes are considered 40 to 60 percent deficient by this methodology.

TABLE II.—IHS RANKING OF TRIBAL GROUPS BY DEFICIENCY LEVEL, APRIL 1984

Percent deficiency	Level	Number of tribes
Less than 20	I	36
21 to 40	II	60
41 to 60	III	156
61 to 80	IV	0
81 to 100	V	0
Total		252

Source: IHS, Program Planning Branch.

The wide variations among IHS areas and tribes with respect to resource allocations and deficiency levels led to the creation of an "Equity Health Care Fund" by the Appropriations Committees; from FY 1981 through FY 1984, the Equity Fund was the source of additional IHS funds for resource-deficient tribes throughout the country. The Appropriations Committees did not earmark a specific amount for the Equity Fund in FY 1985, but the IHS has set aside $5 million for this purpose (a substantial reduction from the $9.87 million provided in FY 1984). It is the Committee's understanding that the Administration has not requested any further funding for the Equity Fund in FY 1986.

The origins of the Equity Fund can be traced back to 1974, when a group of California Indians filed a class action suit against IHS alleging that they had been illegally denied health care services comparable to those offered Indians elsewhere in the U.S. The U.S. Distirct Court ruled in favor of the Indians, finding that, among other things, while 10 percent of the national IHS service population lived in or near reservations in California, the IHS had since 1956 allocated to California no more than 2 percent of its total funds in any one year. The Court ruled that IHS was obligated "to adopt a program for providing health services to Indians in California which is comparable to those offered Indians elsewhere in the United States." On appeal, the District Court ruling was affirmed by the Court of Appeals for the Ninth Circuit. *Rincon Band of Mission Indians* v. *Harris,* 464 F. Supp. 934 (N.D. Cal. 1979), aff'd on other grounds, 618 F. 2d 569 (9th Cir., 1980). The Equity Health Care Fund was initiated in FY 1981 to assist IHS in complying with this decision. For each year during the FY 1981 through FY 1985 period, the amounts available through the Fund to resource deficient tribes in California and elsewhere averaged about 1 percent of total IHS appropriations.

The Committee bill would establish an Indian Health Care Improvement Fund, to be administered by the IHS, for the purpose of assisting the tribes most deficient in health resources. The Secretary is required to detemine the level of health resources deficiency for each tribe. The Fund is to be used to raise all of the tribes ranked below level II deficiency—that is, with a deficiency exceeding 40 percent—up to level II. After this has been accomplished, the IHS is required to use the Fund to raise all of the tribes ranked below a level I deficiency—with a deficiency exceeding 20 percent—up to level I. For this purpose, the Committee bill authorizes $28 million in FY 1986, $29 million in FY 1987, $28 million in FY 1988, and such sums as may be necessary to achieve one third of the goal of raising all tribes to level I deficiency in FY 1989. For the years FY 1987 and thereafter, the IHS must use tribal-specific health plans in developing the deficiency-level rankings for each tribe. Amount received by a tribe from the fund in any given year shall be included in that tribe's budget base for purposes of subsequent funding allocations.

The Committee recognizes that the Health Care Improvement Fund will not, in and of itself, fully resolve the existing inequities in resource distribution among eligible Indians, since it represents such a small percentage of total IHS resources. However, before recommending more fundamental structural change in the allocation of IHS resources, the Committee wishes to give IHS the opportuntiy to remedy the situation through the use of the Fund and of other policy tools already available to it.

Catastrophic Health Emergency Fund

Currently, the IHS allocates health service funds appropriated to it among its various Area and Program Offices, which in turn reallocate the funds among ther various service units. This applies both with respect to funds for direct care provided by IHS or tribal organizations under contract with the IHS, and with respect to funds for "contract care," that is, services purchased from private hosptials and physicians and other non-IHS providers. Because the funds are distributed geographically, and because many service units are underfunded, the occurrence of a catastrophic illness (such as biliary atresia in a child resulting in a need for a liver transplant) or medicl disaster (such as a motor vehicle accident involving serious injuries to several persons) in a particular geographic area can deplete the funds allcoated to that service unti for contract health care. This means either that the affected service unit must further ration the funds available to meet routine health care needs for that fiscal year, or that the IHS must reallocate funds from other service units. In either case, the result is a further reduction in available health care.

The Committee bill establishes an Indian Catastrophic Health Emergency Fund, to be administered by the central office of the IHS, for the purpose of meeting the extraordinary medical costs associated with the treatment of the victims of disasters or catastrophic illness. The Service is required to assure that the Fund will not make any payments on behalf of an eligible patient unless all other potential public and private sources of payment have been exhausted. The Committee bill authorizes $12 million for the Fund

in FY 1986 and, for each of the next three fiscal years, the amounts necessary to maintain the Fund at $12 million. The Committee recognizes that the Fund is only an interim response to the problem now confronting the IHS and the tribes; the Committee bill therefore directs the Secretary to report to Congress, not later than January 1, 1989, on the claims and cost experience under the Fund, so the the Congress can consider improvements in the management of catastrophic illness by the IHS.

Competitive procurement

Under current practice, when the IHS does not offer the particular service needed by an eligible Indian in the reservation or community where he or she lives, the IHS may purchase the services on a "contract care" basis from other providers. Competitive bidding requirements that are usually applicable to government purchases may not be effective at reducing costs when applied to IHS contract care purchases in markets where few providers are willing to bid. In such circumstances, competitive bidding requirements may even jeopardize access to needed care.

The Committee bill authorizes the IHS to waive any statutory or administrative requirement for competitive procurement if, in the judgment of the Chief Medical Officer of each Area or Program Office, competitive procurement would not result in any appreciable savings, or would compromise the accessibility, quality, and continuity of health services. The Committee bill also directs the IHS to reject any bid submitted under competitive procurement procedures if, in the judgment of the Chief Medical Officer for the affected Area or Program Office, the bid is so low or otherwise defective that its acceptance would compromise the accessibility, quality, and continuity of health care services. These exceptions to the competitive procurement requirements apply only with respect to health services, not other goods or services the IHS procures. The Committee expects that in determining whether or not to waive competitive procurement requirements, the Secretary give primary consideration to the anticipated impact of a waiver on the quality of services available to eligible Indians and on their health status.

Preventive health, health protection, and health promotion

In 1979, the Department published "Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention" (PHS Pub. No. 79-55071). In this major report, the nation's highest-ranking commissioned health officer set forth five major public health goals for the nation to be achieved by 1990: (1) a 35 percent reduction in infant mortality; (2) a 20 percent reduction in the deaths of children aged 1 to 14; (3) a 20 percent reduction of deaths among adolescents and young adults to age 24; (4) a 25 percent reduction in deaths among adults aged 25 to 64; and (5) a 20 percent reduction in the average number of restricted activity days for persons aged 65 and over. The Surgeon General then went on to outline a three-pronged strategy to achieve those goals: preventive health, health protection, and health promotion.

The priority preventive health services identified by the Surgeon General are family planning, pregnancy and infant care, immuni-

zations, control and treatment of sexually transmissible diseases, and control of high blood pressure. The principal health protection services are toxic agent control, occupational safety and health, accidental injury control, flouridation of community water supplies, and infectious agent control. Finally, health promotion activities encompass smoking cessation, reduction of alcohol and drug abuse, improved nutrition, exercise and fitness, and stress control.

The IHS is currently engaged in many of these activities, which for appropriations purposes are classified as sanitation, public health nursing, and health education. In addition, the Community Health Representatives (CHR's) provide many of these services to members of their tribes on an outreach basis. The Committee is concerned, however, that, given the potential long-term payoffs, the IHS is not placing sufficient emphasis on these activities.

To focus more effectively the efforts of the IHS, the Committee bill directs the IHS to provide preventive health, health protection, and health promotion services to Indians according to a schedule set forth in a comprehensive plan. This plan is to be developed by the IHS based on plans submitted by each tribe. The Committee expects that the IHS will integrate the information contained in the tribal specific health plans into the policy framework and recommendations set forth in the Surgeon General's report in order that the goals of Healthy People will be realized for the Indian people.

TITLE III. HEALTH FACILITIES

Title III of the Act currently authorizes such sums as may be necessary for the construction and renovation of hospitals, health centers, health stations, staff housing, and other Indian Health Service facilities. Title III of the Act currently authorizes such sums as may be necessary for the construction of safe water and sanitary waste disposal facilities in existing and new Indian homes and communities. In FY 1985, appropriations for health facilities construction totaled $31.6 million, while appropriations for sanitation facilities amounted to $24.5 million. In the view of the Committee, there remains a continuing need to upgrade both the health and the sanitation facilities available to the Indian people. The need far exceeds the resources available in the short run; accordingly, the Committee bill requires the Secretary to establish funding priorities for Congressional consideration.

The Committee bill requires the Indian Health Service (IHS) to submit to the Congress, within 6 months of enactment, a health facilities priority system report. This report must identify and justify the ten highest priority inpatient care facilities (along with required staff quarters), and the ten highest priority ambulatory care facilities (and required staff quarters), and estimate the cost of each of these projects. Finally, the report must contain a description of the health facility needs of tribes or tribal organizations. Similar reports must follow the President's budget submissions for FY 1987, FY 1988, and FY 1989.

Under the Act, health facilities construction and renovation funds are authorized only for facilities operated directly by the IHS. With the enactment of the Indian Self-Determination Act in 1975, however, the Congress established the policy that, where a

qualified Indian tribe so requests the tribe itself must be allowed to deliver health services to its members under contract with the Secretary, rather than depending on the IHS to deliver the services. In order for this principle of self-determination to be given full effect, tribes or tribal organizations contracting with the Secretary must be treated on the same basis as tribes receiving care directly from IHS-operated facilities. Otherwise, tribes will be discouraged from seeking to operate their own health care programs.

The Committee bill therefore requires that, in preparing the health facilities priority system report, the IHS consult with, and review the facilities needs of, tribes or tribal organizations delivering health services under contract. The bill further requires that, in conducting this review and identifying its priorities, the IHS apply exactly the same objective criteria as it uses to evaluate the needs of its own facilities. The IHS is without authority to exclude from the list of the ten highest priority inpatient and ten top priority ambulatory care facility projects those operated by tribes and tribal organizations solely on the grounds that these projects are not operated directly by the IHS. Furthermore, the IHS is without authority to exclude from its priority lists projects in areas, such as California, where the IHS does not operate its own health facilities solely on the grounds that those projects are located in such areas. In determining its facility priorities, the IHS must apply the same, objective criteria in a uniform manner to all tribes and tribal organizations, regardless of the area in which they are located or whether or not they contract to deliver services.

The Committee bill does not authorize the appropriation of any funds for the construction or renovation of health facilities. The authorization for such appropriations is already found in the Snyder Act (the Act of November of 1921), and the Committee believes that the enactment of additional authorizations for this purpose would be unnecessarily duplicative. The Committee bill does clarify, however, that the funds that are appropriated for health facility construction or renovation, whether under the Snyder Act or any other authority, are subject to contract under the Indian Self-Determination Act. Thus, if a tribe applies for health facility construction funds under the terms of the Self-Determination Act, and if the tribe is qualified to contract and its facility project is one of the priority projects under this section, then the secretary must contract with the tribe under the Self-Determination Act to undertake the project.

Safe water supply and sanitary waste disposal facilities

The health status of the Indian population, no less than that of the rest of the U.S. population, is directly related to the availability and aduequacy of the water supply and sanitary waste disposal facilities. Because of this strong relationship, the provision of water supply and sanitation facilities to the Indian people has traditionally been viewed as primarily a health function within the responsibility of the IHS. In recent years, the Office of Management and Budget has taken the position that the provision of safe water and sanitation facilities is primarily a construction function, and the responsibility for building and maintaining these facilities should lie

with the agency that builds or finances the housing, such as the Department of Housing and Urban Development.

In the view of the Committee, the Indian Health Service cannot reasonably be directed—as this bill directs it—to improve the health status of the Indian people without also giving it the ability to improve the water supply and sanitation systems that are integral to the improvement of health status in the disproportionately poor and rural Indian population. Accordingly, the Committee bill explicitly reaffirms that the primary responsiblility for providing necessary sanitation facilities and services rests with the Indian Health Service.

In addition, the Committee bill clarifies the Secretary's existing authority to construct, improve, and maintain, essential sanitation facilities for Indian homes, communities, and lands under the Transfer Act (42 U.S.C sec. 2004a), by explicitly authorizing the IHS to provide financial and technical assistance to Indian tribes and communities in connection with the operation and maintenance of sanitation facilities. The Committee bill also gives the IHS express authority to provide operating and maintenance assistance for, and emergency repairs of, tribal sanitation facilities when necessary to avoid a health hazard or protect the Federal government's investment.

To discharge properly this responsibility, the Secretary is required under the Committee bill to develop and implement a 10-year plan, beginning in FY 1985, to provide safe water supply and sanitary waste disposal facilities to existing and new Indian homes and communities. In addition, the Secretary is required to submit to Congress, within 60 days of enactment, the IHS sanitation facilities priority system, which ranks each Indian community or tribe according to the level of deficiency in its sanitation system. The Committee bill requires, and the Committee wished to emphasize that, in preparing the sanitation facilities priority report, the IHS must consult with all affected tribes and tribal organizations, and must apply the methodology for determining sanitation facilities uniformly to all Indian communities or tribes, regardless of whether the tribe receives health services directly from the IHS or delivers services itself under contract. This sanitation facilities system priority report is to be prepared and submitted annually to the Congress within 30 days of submission of the President's budget for fiscal years 1987, 1988, and 1989.

The Committee bill does not authorize the appropriation of funds for the construction of water supply and sanitary sewage disposal systems. The authorization for such appropriations is already found in the Transfer Act, and the Committee believes that the enactment of additional authorizations for this purpose would be unnecessarily duplicative. The Committee bill does provide an additional authorization of $5,850,000, in each of the fiscal years 1986, 1987, 1988, and 1989, to enable the Secretary to carry out her responsibilities with respect to the provision of financial and technical assistance and emergency repair services to Indian tribes and communities.

The Committee bill also clarifies that all funds appropriated under the Indian Health Care Improvement Act, the Transfer Act, or any other authority for the purpose of providing water supply

and sewage disposal services, are subject to contract under the Indian Self-Determination Act. Thus, if a tribe applies for sanitation facility construction funds under the terms of the Self-Determination Act, and if the tribe is qualified to contract and its project is one of the priority projects under this section, then the Secretary must contract with the tribe under the Self-Determination Act to undertake the project.

Expenditure of nonservice funds for renovation

The Committee bill authorizes Indian tribes to spend certain funds to renovate or modernize any facility of the IHS or any facility operated by the tribe through a contract with the IHS under the Indian Self-Determination Act. The authorization is effective only for renovations or modernizations that do not obligate the Secretary to provide additional employees or equipment, are approved by the appropriate IHS area director, and comply with applicable IHS regulations. This provision applies to tribal funds which are not held in trust by the Secretary of Interior, funds which are held in trust with the approval of the Secretary of Interior, and any funds appropriated under Federal law.

Bethel, Alaska, hospital

The Bethel Native Corporation, a for-profit corporation organized by the Alaska Natives of Bethel, Alaska, pursuant to the Alaska Native Claims Settlement Act, selected certain lands as their entitlement under that Act. Subsequently, in 1979, the IHS constructed a hospital on this land without the consent of the Bethel Native Corporation. In 1983, and again in 1984, the Bureau of Land Management of the Department of Interior determined that the Bethel Native Corporation is entitled to a conveyance of title to this land. An administrative appeal of this determination by the Department of Health and Human Services is currently pending.

The Committee bill provides that, if a final administrative ruling by the Department of Interior sustains the Bureau of Land Management's determination, then title to the land at issue shall be conveyed to the Bethel Native Corporation. The Committee bill authorizes the Secretary of Health and Human Services to negotiate a land exchange with the Corporation. If, within 90 days of the final administrative ruling, no land exchange is agreed to, then the Secretary is directed to negotiate an agreement with the Corporation for the sale and leaseback of the hospital and staff housing facilities on the land. Once negotiated, this sale-leaseback agreement is to become effective 90 days after submission to Congress.

TITLE IV. ACCESS TO HEALTH SERVICES

Grants and contracts with tribal organizations

The Committee bill extends for four years the current authority of the Secretary to make grants or enter into contracts with tribal organizations to assist individual Indians to establish eligibility for Medicare or Medicaid and to pay monthly premiums under Medicare Part B in cases of financial need. The bill authorizes $1.5 million for FY 1986, $2 million in FY 1987, $2.5 million in FY 1988, and $2.0 million in FY 1989 for this purpose. The bill clarifies that

tribal organizations may focus their efforts in a manner consistent with local circumstances: on improving Indian participation in the Medicare program, or on improving Indian participation in the Medicaid program, or on paying monthly Medicare Part B premiums on behalf of indigent Indians who are not eligible for Medicaid, or on some combination of these. Tribal organizations need not undertake all three functions in order to qualify for a grant or contract.

Medicaid provisions

The Committee bill extends the current authority for participation of IHS hospitals or skilled nursing facilities in the Medicaid program to any IHS facility which provides services of a type otherwise covered under a State's Medicaid plan, including health centers, health stations, and home health agencies. As with IHS hospitals and skilled nursing facilities, these other IHS facilities would be required to meet all of the conditions and requirements for participation in the applicable State's Medicaid plan. In cases where the facility has submitted to the Secretary, within 6 months of enactment of this legislation, an acceptable plan for achieving compliance with such conditions and requirements, the facility may participate in the Medicaid program for no more than one year.

The Committee bill modifies the current law requirement that the Secretary place Medicaid payments made to IHS facilities in a special fund to be used to bring those facilities into compliance with the applicable Medicaid conditions and requirements. From the reimbursements collected in this fund, the Secretary would be required to return to each IHS service unit at least 50 percent of the Medicaid payments to which IHS facilities in such service unit are entitled, if these payments are necessary to bring the facilities in the service unit into compliance with applicable Medicaid conditions and requirements. Once compliance has been achieved in a given service unit, the Secretary would be required to apply the Medicaid revenues from the facilities in that unit to the improvement of non-complying facilities in other communities. The purpose of this provision is to give IHS facilities, whether operated by the IHS or by tribal contractors, an incentive to assist qualified patients in establishing their eligibility for Medicaid benefits and to bill for and collect the Medicaid payments to which they are entitled. This provision is effective with respect to payments for services provided on or after enactment.

Study of barriers to Medicaid participation

The Committee bill directs the Secretary, in consultation with Indian tribes and tribal organizations, to report to the Congress within 12 months of enactment on the barriers to Medicare and Medicaid participation by American Indians and Alaska Natives. Particularly with regard to Medicaid, Indian participation is far lower than would be suggested by the 29 percent poverty rate which the 1980 Census recorded among the rural Indian population. The Committee is concerned that poor Indians who desire Medicaid coverage and who are qualified for Medicaid in the States in which they reside may be unable to establish their entitlement to these critical benefits due to unintended programmatic obsta-

cles. The Committee bill requires the Secretary to estimate the number of Indians in each service unit who are potentially eligible for Medicaid or Medicare, and to provide the number actually participating in these programs in each service unit. The Secretary is to identify any such barriers that may exist at either the State or service unit level. The Secretary shall also provide recommendations for the removal of these barriers and for other measures which would encourage the participation of Indians and Alaska Natives in Medicare and Medicaid. While primary concern of the Committee lies with the barriers to participation by Indians otherwise eligible for these programs, the Committee also intends that the Secretary identify and make recommendations regarding any eligibility requirements or standard that have a particularly or disproportionately exclusionary effect upon indigent Indians.

TITLE V. HEALTH SERVICES FOR URBAN INDIANS

Title V of the Indian Health Care Improvement Act authorizes the IHS to enter into contracts with urban and rural Indian organizations to provide outpatient health services and referrals to Indians who are not residing on or near reservations served by the IHS. Currently, the IHS provides $9.8 million under Title V to 37 urban Indian health projects in cities in 29 different States.

The Committee bill deletes the current authorization for rural Indian health contractors and revises the authorization for urban Indian projects. As of 1980, nearly 613,000 Indians—nearly half of the total Indian population in the 28 reservation States—lived in urban areas. A significant number of these now rely on the urban Indian projects now funded under Title V; in fiscal year 1983, about 82,000 Indians used the services of these projects on one or more occasions.

Direct IHS funding is only one source of revenue for most urban Indian projects. Nationally, about 44 percent of all Title V projects come from the IHS; the rest derives from public and private third party payments; State, county, and city contributions; patient collections; charitable contributions; and other sources. Removal of the core Title V funding would, in most cases, result in the financial collapse of the project. The Committee has required, but has not received, adequate documentation that sufficient numbers of qualified providers are ready and willing to care for the Indian patients now being seen by these projects should they cease operations. The Committee bill, therefore, proposes to continue assistance to these vital organizations.

Under the Committee bill, the IHS would be authorized to continue to enter into contracts with urban Indian organizations to provide health or referral services. In addition, the Committee bill would authorize the IHS to contract with urban Indian organizations to determine the unmet health needs of the Indians in their communities. The Committee bill further directs the IHS to conduct annual on-site evaluations of each contracting organization to determine whether the requirements of Title V are being met.

The Committee bill proposes authorizations of $9.8 million in FY 1986, $10.1 million in FY 1987, $10.4 million in FY 1988, and $10.8 million in FY 1989 for contracts with urban Indian organizations.

TITLE VI. ORGANIZATIONAL IMPROVEMENTS

Establishment of the Indian Health Service as an agency of the Public Health Service

The Committee bill directs that the Indian Health Service be elevated within the Public Health Service of the Department of Health and Human Services to an organizational status equivalent to that of the Health Resources and Services Administration. This reorganization is to take effect within 9 months after enactment.

The IHS is the organizational entity that has as its mission the discharge of the Federal trust responsibility to provide health care for American Indians and Alaska Natives. With over 11,000 permanent staff positions, and a budget of $856 million, the IHS operates the largest direct health delivery system within the Department of Health and Human Services. It administers some 51 hospitals, 84 health stations, and more than 550 smaller health stations and satellite clinics in 21 different States. It also manages a network of 37 urban health projects in 22 states.

Currently, the IHS is one of four bureaus within the Health Resources and Services Administration (HRSA), which in turn is one of the six major agencies within the Public Health Service. (The other major PHS agencies are the Alcohol, Drug Abuse, and Mental Health Administration; the Centers for Disease Control; the Food and Drug Administration; the National Institutes of Health, and the Agency for Toxic Substances and Disease Registry). In the view of the Committee, the mission of IHS and the scope of its programmatic responsibilities are commensurate with an organizational status equivalent to that of the six major PHS agencies.

Management Information System; access to patient's records

The Committee bill directs the Secretary to establish an automated management information system for the IHS, including a cost accounting system, a patient care information system for each area served by the IHS, and a privacy component that protects the privacy of patient medical and financial information held by the IHS.

It is the intention of the Committee that the management information system be developed only after the IHS has made a thorough evaluation of its own information needs and those of tribal contractors and local service units. The Committee further expects that the IHS, in developing its management information system, consult closely with tribes and tribal organizations and make every effort to integrate tribal information systems with the IHS system. Finally, the Committee intends that the privacy of patient information held by, or on behalf of the IHS, be the foremost consideration in the development of the management information system. In developing a privacy component, the Secretary is expected to limit unauthorized disclosure of identifiable patient medical information to the maximum possible degree, consistent with the essential needs of law enforcement and public health agencies.

Under the Committee bill, each patient whose care is provided or paid for by the IHS is entitled to reasonable and prompt access to his or her medical or health records. The Committee understands

medical or health records to include any material, whether or not in writing, that contains information relating to the health, examination, care, or treatment of a patient. The Committee intends that an IHS-operated or funded facility allow patients (or their designated representatives) to inspect and copy their own medical or health records except where, in the exercise of reasonable medical judgment, the facility determines that disclosure of the records would cause grave mental or physical harm to the patient. The Committee further expects that, in those cases when a facility denies a patient access to his or her records, the facility promptly provide a written explanation of the reasons for denial.

The Committee bill also requires that, by September 30, 1988, the IHS provide automated management information systems to all tribal health organizations delivering care in California, and all urban health projects delivering care in California. These systems must meet the management information needs of each tribe or organization.

In California, all IHS clinical services are provided through contracts with tribes or tribal health organizations in clinics that are not Federally owned. Although these tribal providers rely heavily on non-IHS third party revenues for fiscal stability, almost none of them has automated claims processing or patient records systems. As a result, the California tribal health programs have not had the billing and accounting capacity needed to fully maximize alternate resources to supplement their IHS funds. Moreover, the IHS is unable at this time to provide itself, the Congress, or the tribes with accurate, basic health status, cost, and utilization information for California Indians. An accurate, comparable data base is essential to the effective program management by the tribal organizations, by the IHS, and by the Congress.

Under the Committee bill, California tribal health organizations retain the right to determine the necessary systems configuration most suited to their needs, consistent with Departmental procurement regulations. The language used by the tribal management information systems must, of course, be compatible with the system the IHS selects for its own facilities. Similarly, the tribal health organizations are required to comply with any reporting requirements established by the IHS for the facilities the IHS operates directly. However, the Committee bill is not to be construed to give the IHS the right to access data directly from the tribal health organization without the consent of the organization.

The Committee bill does not authorize additional funds for this purpose. The Committee expects that the necessary resources will be drawn from the funds allocated to the California program office for this and other administrative purposes. The Committee specifically intends that the IHS not redirect clinical care or other nonadministrative funds to this purpose.

TITLE VII. MISCELLANEOUS

Leasing and other contracts

Under current law, the Secretary of Health and Human Services is authorized to lease tribal facilities for health purposes for periods not in excess of 20 years. In addition, the Secretary is permit-

ted to reconstruct or renovate the leased facilities with the consent of the tribe. While it has always been the intent of Congress that this provision be given a liberal construction to further the improvement of Indian health and to provide a greater role for Indian tribes in the delivery of health care, some tribes have reported that they have encountered difficulty with the Department in the use of this authority, particularly in the area of allowable costs which could be included in the lease rentals.

The Committee bill clarifies that the Secretary's authority to include in lease rentals an allowance for costs incurred by the tribes in using the leased facilities, including rent, depreciation, principal and interest paid or accrued, and operation and maintenance expenses.

Juvenile alcohol and drug abuse

The Committee bill authorizes a new initiative relating to alcohol and drug abuse among Indian youth. The Committee is deeply concerned by the prevalence of alcohol, drug, and inhalent abuse among Indian youth, and by the absence of a coordinated, effective response to this problem. Early intervention can prevent the development of chronic, life-long drug or alcohol abuse. Yet of the approximately 200 IHS alcohol programs, only one is geared directly toward juveniles. It is the Committee's understanding that, in general, Indian youth who are arrested in connection with alcohol or drug-related incidents are either placed in adult jails or are released without treatment or counseling. There are reportedly few counselors in Bureau of Indian Affairs or other schools with large Indian populations who have the expertise to deal effectively with drug and alcohol abuse. Educational curricula, especially those relevant to Indian youth, seem to be generally lacking.

The Committee bill therefore requires that the Secretary coordinate through a formal interagency agreement, the efforts of the Department of Health and Human Services relating to alcohol and drug abuse among Indian youth with the efforts of the Department of Interior and the Department of Education. The Committee bill further requires the IHS to develop and implement a program to train elementary and secondary teachers and counselors in schools with significant numbers of Indian students on the prevention, identification, and counseling of alcohol and drug abuse. The appropriation of $1.5 million in each of the next four fiscal years is authorized for this purpose. Finally, the Committee bill directs the Secretary to establish within the IHS an Office of Alcohol and Drug Abuse to administer both juvenile and adult alcohol and drug abuse programs.

Nuclear resource development health hazards

The 1980 amendments to the Indian Health Care Improvement Act directed the Secretary to conduct a study of the health hazards to Indian miners and Indians on or near Indian reservations associated with nuclear resource development. Rather than conduct the required study, the Secretary merely submitted to Congress a survey of existing literature on nuclear resource development. Accordingly, the Committee bill provides that the Secretary enter into an arangement with the National Academy of Sciences to con-

duct such a study. The results of the study are to be submitted to the Congress within 18 months of enactment of this bill. The Committee bill authorizes the appropriation of $350,000 for this purpose.

Arizona as a contract health service delivery area

The Act currently designates Arizona as a contract health service delivery area (CHSDA), authorizing $2 million in FY 1984 for this purpose. The Committee bill revises and extends this designation and authorization through FY 1989. Under the statewide CHSDA, contract health care services would be available only to members of Federally recognized Indian tribes of Arizona. The Committee bill authorizes for this purpose $7.7 million in FY 1989, $8.2 million in FY 1987, $8.8 million in FY 1988, and $9.4 million in FY 1989.

Eligibility of California Indians

The Act current provides that Indians in the State of California who are members or descendants of members of former Federally recognized tribes of the State of California are eligible for IHS services. This provision expired on September 30, 1984.

The Committee bill provides that, effective on enactment, the following California Indians are eligible for care from the IHS, whether the funds for such care are appropriated under the Indian Health care Improvement Act, the Snyder Act, the Indian Self-Detemination Act, or any other authority: (1) any member of a Federally-recognized tribe; (2) any descendant of a Indian who was residing in California on June 1, 1852, and who is living in California, is a member of the Indian community served by a local program (including programs that may be established in the future), and is regarded as an Indian by the community in which he or she lives; and (3) any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California. The Committee bill further provides that, until September 30, 1988, any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such Indian, is eligible for care from the IHS. The California Indian population described in this section is eligible for the same range of servies provided to eligible Indians outside of California, including direct and contract care.

The purpose of this provision is to codity existing IHS policy and practice with respect to the eligibility of California Indians for IHS services. According to the IHS, there were 313, 859 Indians in California in 1984. Of these, the IHS considered 72,385 to be its "service population"—that is, those Indians for whom, under current policy, the IHS acknowledges a responsibility to provide health care. This complex distinction between Indian and "service Indians" in California is the product of lengthy historical and legal evolution from 1850, when California first joined the Union. The Committee bill does not eliminate this distinction but rather clarifies it. In the view of the Committee, it is essential to create a specific, permanent definition of eligible California Indian to provide guid-

ance for both the IHS and the Indian people themselves, and to avoid unnecessary litigation on this matter.

This provision can only be understood in historical context. When Congress in the 1850's was first presented with treaties that the Federal government had entered into with Indian tribes in California, it failed to ratify them. Members of tribes whose treaties were not ratified were eventually recognized in Federal law as individual "Indians of California" for purposes of compensation, 25 U.S.C. sec. 651. Some were give allotments on public lands instead of tribal status. Others were belatedly recognized with the creation of "rancherias" for homeless Indians, only to have their status terminated a few decades later. Still others were placed on reservations and today remain members of Federally-recognized tribes.

The purpose of this amendment is to identify each of these categories of California Indians by reference to objective criteria which are readily ascertainable. While an individual may fall into more than one category, it is only necessary that he or she meet the requirements of one of the four categories in order to become eligible for health care through the IHS. It is the Committee's understanding that its amendment does not increase the IHS "service population" in California, because each category is composed of persons now eligible by law, regulation, or IHS policy. The Committee amendment is, however, intended to protect members of the current IHS "service population" from any loss of eligibility as a result of potential future administrative policy changes.

California as a contract health service delivery area

The Committee bill requires the IHS to designate the entire State of California as contract health service delivery area (CHSDA) for the purpose of providing contract health services to eligible Indians in California, with the exception of the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, and Santa Clara.

Under current policy, the IHS purchases services that are not available to eligible Indians through the IHS or tribal delivery systems from other, generally private, providers. The IHS maintains approximately 1,300 contracts with health care providers, predominantly physicians in the private sector, for services on a regular basis. In addition, numerous pruchase orders are issued during the course of a year for limited services, such as emergency care, from providers not used on a regular basis. In FY 1985, the IHS will spend nearly $164 million, or about 19% of its total budget, on contract care.

In part because contract care funding is so limited relative to need, eligibility for contract care is more limited than that for direct care. Under applicable IHS regulations, 42 C.F.R. sec. 36.23, contract health services are limited to eligible Indians who reside within a contract health service delivery area (CHSDA), as designated by the IHS. Currently, the entire States of Alaska, Arizona, Oklahoma, and Nevada are designated as CHSDA's. In other States, only certain counties or areas are designated as CHSDA's. In California, for example, there are 27 different CHSDA's. If a California Indian does not live within one of these areas, all of which are counties, he or she cannot qualify for needed contract

care, even though he or she is otherwise eligible for direct care from the tribal health organizations funded by the IHS and lives within the service area of that tribal program. In California, many eligible rural Indians live in counties that have no land base or reservation, are therefore not designated as CHSDA's, but are nonetheless within the service area of a tribal health program.

The Committee finds this indefensible. If a California Indian is eligible for IHS services, lives within a tribal contractor's service area, and has no alternate resources, needed contract care should not be denied because the individual lives in the wrong county. The Committee bill therefore increases the number of counties in which eligible rural California Indians reside that are designated as CHSDA's. The Committee bill does not, however, expand the number of persons eligible for IHS-funded services in California. Eligibility for contract care services is limited to those individuals meeting the requirements of section 709 of the Act, as amended by the Committee bill, or to those individuals who are eligible under current IHS regulations at 42 C.F.R. sec. 36.23. It is, of course, unnecessary for an individual to meet the requirements of both section 709 and 42 C.F.R. sec. 36.23 in order to qualify for contract care; compliance with either set of requirements is sufficient. However, the Committee bill does remove the indefensible geographic restrictions on the ability of an otherwise eligible California Indian to receive contract care.

The Committee notes that a number of counties that are included in the California contract health service delivery area under this provision are also served by urban Indian health projects receiving funds under Title V of the Act. These counties include Fresno, Kern, San Diego, Santa Barbara, and Ventura. It is the intent of the Committee that the urban Indian health projects in these counties continue to serve the urban Indians residing in the urban centers in which the projects are located. This provision is not to be construed as limiting in any way the need for urban Indian health projects in California.

Contract health facilities

The Committee bill directs the IHS to fund programs and facilities operated by tribes and tribal organizations under contract with the IHS under the Indian Self-Determination Act on the same basis as the IHS funds the programs and facilities it operates directly. The Committee bill expressly requires that this rule of equal treatment apply with respect to funding for (1) the maintenance and repair of clinics owned or leased by the tribes or tribal organizations; (2) employee training; (3) cost-of-living increases for employees; and (4) any other expenses relating to the provision of health services.

Section 106(h) of the Indian Self-Determination Act provides, in relevant part, that "the amount of funds provided under the terms of contracts entered into [by the Secretary of Health and Human Services with tribal organizations for the provision of health services] shall not be less than [the Secretary] would have otherwise provided for his direct operation of the programs or portions thereof for the period covered by the contract * * *." This principle of equal treatment is essential to the achievement of Indian self-de-

termination; if a tribe will receive less resources as a result of contracting, it obviously will have little incentive to request that the Secretary contract with it.

The purpose of the Committee bill is to clarify the meaning of this equal treatment policy in the context of health services. The Committee received testimony that, at least in California, where all health services are delivered by tribal organizations, the IHS does not provide funding to the tribal contractors for such items as maintenance and repair, staff training, and, until this year, mandatory cost-of-living increases. In addition, according to testimony presented to the Committee, the IHS does not allocate its own health professional staff to tribally-operated programs on the same basis as it does to the programs it operates; as a result, tribal contracts often face great difficulty in recruiting and retaining health professionals.

The Committee understands that IHS-operated facilities in other areas do receive funding for these functions. The lack of such funding has a serious adverse impact on the ability of tribes to deliver quality health care through their own organizations. The intent of the Committee bill is to eliminate any financial disincentive that a tribe might have to deliver services under contract rather than rely on IHS to deliver the services by assuring that tribes and tribally operated programs receive funding for all budget activities that is equivalent to the IHS-operated programs and facilities.

The Committee bill does not authorize additional appropriations for the purpose of achieving equal treatment of tribal contractors. It is the intent of the Committee that the costs of equalization be funded from current IHS resources.

The Committee bill also provides that, in the case of California Indians only, the necessary consent of eligible Indians who are not members of Indian tribes shall be presumed to have been given unless 51 percent of these Indians object prior to the award of the contract. The objection may be made either individually, or through any representative, legally established organization of Indians. Whenever consent is not granted, the Committee bill directs the IHS to make alternate arangements for the delivery of health care services to these Indians. In making the alternate arrangements, the IHS may (1) provide services through its own facilities, (2) purchase services on a contract basic, (3) contract with a representative organization to provide services under the Buy Indian Act, or (4) make other effective arrangements for the delivery of health services to these Indians.

Under section 1(b) of the Transfer Act, 42 U.S.C. sec. 2001(b), the Secretary is authorized to contract with private or public agencies or organizations to deliver health services to eligible Indians, but only "with the consent of the Indian people served." It is the Committee's understanding that the IHS has taken the position in pending litigation that current law does not require the consent of eligible Indians who are not affiliated with Federally-recognized tribes to the award of contracts for the provision of health care under the Indian Self-Determination Act. The Committee amendment makes clear that such consent is, and always has been, required, and sets forth a method for determining consent.

National Health Service Corps

The Committee bill prohibits the Secretary from removing a member of the National Health Service Corps (NHSC) who is performing obligated service from an IHS or tribally-operated health facility, or from withdrawing funds used to support a NHSC assignee, unless the Secretary, acting through the IHS, has assured that the Indians receiving care from the NHSC member will experience no reduction in services.

The Secretary has adopted a policy of removing NHSC assignees from sites for which the IHS is responsible to non-Indian sites of high priority need. The basic rationale for this policy is that the IHS represents an "alternate resource" on which these sites can draw, and that limited NHSC obligees should be targeted on other health manpower shortage areas without similar resources. According to the IHS, there were, as of January 1, 1984, 54 NHSC assignees (physicians, dentists, and other professionals) providing health services to Indians at 26 different sites throughout the country. Of these, 29 have already left the Indian clinics and other facilities where they were originally placed. An additional 6 are scheduled to leave in 1985, and 9 are scheduled to depart in 1986 (the remainder are career Public Health Service Commissioned Corps officers).

It has come to the Committee's attention that, in a number of instances, the IHS has been unwilling to make up the loss of an NHSC assignee, either by providing the site with another practitioner or by making adequate funds available in a timely manner to enable the site to recruit and hire a replacement. The Committee is unwilling to see accessibility or continuity of care to Indians in underserved areas compromised due to the IHS's failure to provide the "alternative resources" on which the Secretary's NHSC relocation policy is premised. The Committee bill therefore prohibits the Secretary from removing a NHSC assignee until and unless the IHS has made available a replacement, or the IHS has given the site adequate funding and time to recruit a replacement. This applies to both sites operated directly by the IHS and sites operated by tribal organizations under contract with the IHS under the Indian Self-Determination Act.

It is not the intent of the Committee to prevent the Secretary from removing a salaried NHSC member from an Indian site if the IHS has made sufficient funds available to that site to allow the retention of an NHSC assignee on a private practice option basis. Nor it is the intent of the Committee to prevent the Secretary from removing a NHSC assignee if the site is, based on accurate and current data, no longer a health manpower shortage area. It is, however, the intent of the Committee to prevent any loss or discontinuity of services to Indian sites as a result of the relocation of NHSC placements.

Service to ineligible persons

Under current regulations, the IHS will provide or pay for services for persons who are not eligible Indians only in the following cases: (1) to persons in need of emergency care; (2) to a non-Indian woman pregnant with an eligible Indian's child through the prenatal and postpartum period; and (3) to non-Indian members of an eli-

gible Indian's household if the medical officer in charge determines that this is necessary to control acute infectious disease or a public health hazard. Emergency patients who are able to pay, as determined by the Service Unit Director, are liable for payment for the care they receive.

The Committee bill revises and codifies policies governing the provision of IHS-funded or IHS-provided health care services to persons who are not otherwise eligible. These policies apply to services rendered by IHS-operated facilities, services furnished by tribal health organizations under Indian Self-Determination Act contracts, and services purchased from non-tribal providers on a "contract care" basis.

With respect to children 18 years or younger who are natural, adopted, legal wards, or orphans of eligible Indians and are not otherwise eligible for IHS benefits, the Committee bill provides that these children are to be considered eligible for IHS-delivered or IHS-funded care without liability for payment.

With respect to non-Indian spouses of eligible Indians, or spouses of Indian descent who are not otherwise eligible for IHS benefits, the Committee bill provides that these individuals are not to be considered eligible for IHS-funded or IHS-delivered care unless they are made eligible, as a class, by an appropriate resolution of the governing body of the relevant Indian tribe. If made eligible, these spouses are not liable for payment.

With respect to other ineligible persons living in the service area of an IHS-operated or IHS-funded facility, the Committee bill provides that they may be made eligible for services if (1) there is no reasonable alternative source of medical care for such persons and (2) services to eligible Indians will not be compromised. Individuals made eligible to receive services from IHS-operated or IHS-funded facilities under this provision are liable for payment for at least the actual cost of the services. In the case of IHS-operated facilities, the IHS is authorized to extend eligibility to such persons only upon the request of the affected Indian tribes. In the case of facilities funded by the IHS through contracts under the Indian Self-Determination Act, the decision as to whether to extend eligibility rests solely with the governing body of the contracting tribe or tribal organization.

Finally, with respect to other ineligible persons, including persons living outside the service area of an IHS-operated or IHS-funded facility as well as persons not made eligible under the previous authorities, the Committee bill authorizes the IHS to provide services in the following cases: (1) to stabilize a medical emergency; (2) to prevent the spread of a communicable disease or otherwise deal with a public health hazard; (3) to provide care to non-Indian women pregnant with an eligible Indian's child for through the post-partum period; and (4) to treat immediate family members of an eligible person where the care is directly related to the treatment of the eligible person.

Restrictions on the use of Indian Health Service appropriations

The Committee bill provides that, unless otherwise specifically provided by law, any restriction placed on the use of appropriations for Indian health service to promote public support for, or opposi-

tion to, any legislative proposal, shall not be interpreted (1) to apply to the use of funds other than Indian health services appropriations by an entity contracting with the Indian Health Service, or (2) to prohibit the support of litigation with such other funds, or (3) to prohibit the promotion of public support for, or opposition to, any legislative proposal with such other funds. The Committee bill further expressly prohibits the IHS from offsetting or limiting the amount of funds obligated to any tribe or tribal health organization under contract with the IHS because of the use of non-IHS appropriated funds for the purposes of litigation, lobbying or other forms of advocacy.

Tribes and tribal organizations that provide health services under contract with the IHS under the Indian Self-Determination Act commonly receive funds from a variety of sources, including the IHS contract payments, other Federal grant funds, State or local funds, out-of-pocket payments by patients, and third party reimbursements, such as Medicare, Medicaid, and private health insurance payments. It has come to the Committee's attention that the IHS is, in some instances, attempting to restrict the use of non-IHS revenues received by tribal contractors with regard to lobbying and litigation, and has even threatened to reduce the contract award to a tribal organization by the amount of non-IHS funds spent on these and other advocacy activities.

The Committee is deeply disturbed by this. There is, of course, no question that the IHS has the duty to enforce statutory restrictions on lobbying and litigation by tribal contractors where these activities are directly financed with funds appropriated to the IHS and awarded to the contractors, and where those restrictions clearly apply to funds appropriated to the IHS. However, this duty does not give the IHS license to extend its regulatory reach into the lobbying, litigation, or other advocacy efforts of tribal health contractors when that conduct is financed from other public or private revenues that are not IHS appropriations. The current IHS policy poses a potential for oppressive governmental control of tribes and tribal contractors that the Committee simply will not tolerate.

In response to an inquiry from the Committee, the IHS took the position that all "program income" is subject to IHS restrictions on the use of IHS funds for lobbying and litigation. The IHS defines "program income" as "income earned from any source, Federal or non-Federal, by a contractor from activities whose costs are properly allocable to contract funds." This evidently includes third-party reimbursements for health services, whether from public payors or private insurers, as well as patient out-of-pocket payments. The Committee bill expressly rejects this IHS policy.

The Committee intends that whatever statutory restrictions on lobbying and litigation the IHS enforces are applied only to the activities of tribal contractors that are directly financd by funds appropriated for the IHS. The IHS is without authority to reduce its funding to tribal contractors by the amount of lobbying, litigation, or other advocacy expenses that a contractor incurs and pays for from other, non-IHS revenues. To require a contractor to return IHS funds as an offset for lobbying or litigation activities paid for by non-IHS funds would be to penalize the contractor financially for exercising rights basic to this democracy: the right to vigorously

assert one's interests, the right to petition one's elected representatives, and the right to secure redress of grievances in the courts. Of course, tribal contractors participating in Medicare or Medicaid, like other participating providers, are subject to any statutory restrictions applicable under those programs with regard to the use of those Federal program funds.

Infant and maternal mortality

The Committee bill requires that, no later than January 1, 1985, the Secretary develop and begin implementation of a plan to reduce (1) the rate of Indian infant mortality in each IHS Area or Program Office to the lower of 12 deaths per 1,000 live births, or that of the U.S. population; and (2) the rate of maternal mortality in each IHS Area or Program Office to the rate of 5 deaths per 100,000 live births. The Committee bill directs the Secretary to report to Congress on January 1, 1986, and each year thereafter, on the progress made toward achieving these objectives.

In 1980, the Surgeon General issued "Promoting Health/Preventing Disease; Objectives for the Nation." This document sets forth specific, measurable, objectives, developed under Public Health Service sponsorship, in 15 national health priority areas. With regard to improving infant mortality, the Surgeon General specifies that by 1990, no county and no racial or ethnic group of the population (e.g., black, Hispanic, Indian) should have an infant mortality rate in excess of 12 deaths per 1,000 live births. (According to the IHS, the Indian infant mortality rate during the 1978–1980 period was 14.6 per 1,000 live births). With regard to maternal mortality, the Surgeon General specifies that by 1990, the maternal mortality rate should not exceed 5 per 100,000 live births for any county or for any ethnic group (e.g., black, Hispanic, American Indian). In 1978, the overall rate was 9.6; the rate for Indians was 12.1.

The Committee can see no reason why these objectives cannot, or should not, be achieved in each IHS Area or Program Office. The Committee notes that, while the infant mortality rate for American Indians and Alaska natives as a whole in 1981 was 11.6 deaths per 1,000 live births, and infant mortality rate among Alaska Natives that year was 17.3. The Committee expects the IHS to give priority to the elimination of such disparities among Area or Program Offices. The Committee bill does not authorize additional appropriations for this purpose. It is the intent of the Committee that these objectives be achieved through more focussed and effective management of current IHS resources.

Contract Health Services for the Trenton service area

The Committee bill directs the IHS to provide contract health services to eligible members of the Turtle Mountain Band of Chippewa Indians residing in the counties of Divide, McKenzie, and Williams in North Dakota, or in the adjoining counties of Richland, Roosevelt, and Sheridan in Montana. No additional funds are authorized. The purpose of this provision is to codify current IHS practice previously authorized under appropriations acts.

Indian Health Service and Veterans' Administration health facilities and services sharing

Under current law and practice, IHS health facilities generally serve only eligible Indians, except in emergency cases and certain other limited circumstances. Similarly, Veterans' Administration facilities generally serve only eligible veterans, except in emergency cases. These patient service policies remain in effect even when an IHS or VA facility has excess capacity available to deliver care to other categories of patients. In New Mexico, for example, there is only one VA Hospital, but there are 8 IHS hospitals, many of which are located in rural medically underserved areas and have unused capacity. In this case, it appears to the Committee reasonble to consider allowing non-Indian veterans who prefer to do so to use a nearby IHS hospital that is able to provide the needed care rather than requiring them to travel great distances to the VA facility.

Accordingly, the Committee bill directs the Secretary of Health and Human Services to study the feasibility of arrangements between the IHS and the VA for sharing medical facilities and services and to support to Congress with recommendation by September 30, 1986. The bill expressly prohibits the Secretary from making any recommendations or taking any action that would impair the priority access or quality of care available to any Indian through the IHS, or that would impair the priority access or quality of care available to any veteran through the VA. The bill also prohibits the Secretary from making any recommendation or taking any action that would adversely affect the eligibility of any Indian to receive health services through the IHS or the eligibility of any Indian who is a veteran to receive health services through the VA.

Navajo Alcohol Rehabilitation Demonstration Program

Alcoholism and alcohol abuse are major health and social problems for Native Americans. In 1980, the age-adjusted death rate from chronic liver disease and cirrhosis, one of the consequences of alcoholism, was three and one half times greater for Indians than for the general U.S. population. The age-adjusted death rate from accidents, many of which are related to alcohol abuse, was 2.5 times higher for Indians than for the U.S. population as a whole. The problem is particularly acute in the Navajo Nation, where the IHS estimates that over 40 percent of the population is directly or indirectly affected by alcoholism, and nearly half of the admissions to IHS facilities are alcohol-related. Testimony given before the Committee's Health and the Environment Subcommittee indicates that the IHS acute care facilities now serving the Navajo Nation do not have the capacity to provide long-term residential treatment for the adult alcoholic.

The Committee bill authorizes a 3-year demonstration program, funded at $400,000 per year, for the rehabilitation of adult Navajo Indians suffering from alcoholism or alcohol abuse in a free-standing residential facility. The bill directs the Secretary to make grants to the Navajo tribe to establish the program in Gallup, New Mexico, where, according to testimony from State and tribal offi-

cials, the incidence of alcholism and alcohol abuse is especially high. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is to evaluate the demonstration and to report to the Congress by January 1, 1989. The Committee expects that, in designing the demonstration project, both the IHS and the Navajo Nation will consult with the NIAAA in order to facilitate that agency's evaluation efforts. No less than 90 percent of the funds are to be applied to rehabilitation services.

Study of health care needs of Native Hawaiians and other native Pacific islanders

The Committee bill directs the Secretary to study, and report to the Congress within one year after enactment, the physical and mental health care needs to Native Hawaiians and other Native American Pacific Islanders, including the barriers to access to Health care services facing this population. The purpose of the study is to assess the health status and the unmet health care needs of these population groups. In conducting this study, the Secretary is to consult with representatives of Native Hawaiians and other Native American Pacific Islanders. No additional funds are authorized for this purpose; the Committee expects that the study would be conducted with existing Departmental administrative resources.

Effective dates

Unless otherwise specified, the provisions in the Committee bill are effective upon enactment.

Hearings

The Committee's Subcommittee on Health and the Environment held a hearing on H.R. 1426 on March 8, 1985. Testimony was received from seven witnesses, representing seven organizations, including national rural and urban Indian health organizations and tribal health organizations from California, New Mexico, and Oregon. Additional material was submitted by four individuals and organizations.

Committee Consideration

On April 4, 1985, the Subcommittee on Health and the Environment met in open session and ordered reported the bill H.R. 1426, as amended, by a voice vote, a quorum being present. On May 9 and May 15, 1985, the Committee met in open session and ordered reported the bill H.R. 1426, with amendment, by voice vote, a quorum being present.

Committee Oversight Findings

Pursuant to clause 2(1)(3)(A) of Rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made by the Committee. In connection with its consideration of this bill, the Subcommittee on Health and the Environment issued a staff report, "Indian Health Care: An Overview of the Federal Government's Role," Committee Print 98–Y (April 1984).

Committee on Government Operations

Pursuant to clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

Committee Cost Estimate

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the cost incurred in carrying out H.R. 1426, stated in budget authority, would be $73.8 million in fiscal year 1986, $76.1 million in fiscal year 1987, $76.4 million in fiscal year 1988, and $60.8 million in fiscal year 1989.

Congressional Budget Office Estimate

U.S. Congress,
Congressional Budget Office,
Washington, DC, May 16, 1985.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for H.R. 1426, the Indian Health Care Amendments of 1985, as ordered reported by the House Committee on Energy and Commerce on May 15, 1985.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

Rudolph G. Penner, *Director.*

congressional budget office cost estimate

1. Bill number: H.R. 1426.
2. Bill title: Indian Health Care Amendments of 1985.
3. Bill status: As ordered reported by the House Committee on Energy and Commerce on May 15, 1985.
4. Bill purpose: H.R. 1426 would revise and extend the Indian Health Care Improvement Act.
5. Estimated cost to the Federal Government:

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990
Authorization levels:					
Indian health manpower programs	6.5	6.7	6.9	7.2	.....
Indian health care improvement fund[1]	28.0	29.0	28.0	12.0	.....
Indian catastrophic health emergency fund[1]	12.0	12.0	12.0	12.0	.....
Water and sanitation	5.9	5.9	5.9	5.9	.....
Access to health services	1.5	2.0	2.5	2.0	.....
Health services for urban indians	9.8	10.1	10.4	10.8	.....
Training of BIA teachers	1.5	1.5	1.5	1.5	.....
Study of health hazards to Indians from nuclear development	.5	.3	.....	.....	.....
Arizona as a contract health service delivery area	7.7	8.2	8.8	9.4	.....

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990
Alcohol rehabilitation demonstration	.4	.4	.4		
Total estimated authorization levels	73.8	76.1	76.4	60.8	
Estimated outlays:					
Indian health manpower programs	4.9	6.3	6.8	7.1	1.8
Indian health care improvement fund	21.0	27.4	28.1	16.1	3.8
Indian catastrophic health emergency fund	9.0	11.4	12.0	12.0	3.0
Water and sanitation	4.4	5.6	5.8	5.9	1.5
Access to health services	1.1	1.8	2.3	2.1	.5
Health services for urban Indians	7.3	9.6	10.3	10.7	2.7
Training of BIA teachers	1.1	1.4	1.5	1.5	.4
Study of health hazards to Indians from nuclear development	.5	.3			
Arizona as a contract health service delivery area	5.8	7.7	8.6	9.3	2.3
Alcohol rehabilitation demonstration	.3	.4	.4	.1	
Total estimated outlays	55.4	71.9	75.8	64.8	16.0

[1] Estimated authorization levels.

The costs of this bill fall within function 550.

Basis of estimate

Most authorization levels are stated in the bill. CBO assumes that all stated authorized amounts are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of recent program data.

The Indian Health Care Improvement Fund authorization levels for fiscal years 1986 through 1988 are stated in the bill. These funds would be used to raise 121 tribes to a level where they have a 40 percent deficiency of health resources. According to the Indian Health Service (IHS), $47 million is needed to accomplish this. The Indian Health Care Improvement Fund authorization levels stated in the bill for fiscal years 1986 through 1988 total $85 million; $38 million more that is needed to raise tribes to the 40 percent deficiency level.

The remaining $38 million of authorization could be used in fiscal year 1989 to begin to raise an additional 99 tribes to a 20 percent deficiency level. Such sums as may be necessary are authorized in this year. IHS estimates that this would require an additional $150 million. It is the Committee's intent, however, that these additional funds be authorized over the three-year period of fiscal years 1989 to 1991. Only $12 million of additional authorization would be needed in fiscal year 1989 to reach the one-third, $50 million, level.

The bill also authorizes $12 million in fiscal year 1986 for the Indian Catastrophic Health Emergency Fund. It authorizes such sums as may be necessary in fiscal years 1987, 1988, and 1989 to return the Fund to a level of $12 million. CBO assumes that this authorization would not allow repeated draining and refilling of the Fund during any one fiscal year. Rather, the authorization will simply limit aggregate annual appropriations to the Fund to $12 million.

The bill also newly designates California as a contract health service delivery area and provides funding for employee training,

cost-of-living adjustments and maintenance and repair in tribally operated IHS programs and facilities. The bill authorizes preventive health services and the development and implementation of a plan to reduce infant maternal mortality rates among Indians. It also authorizes a study on Native Hawaiian health care needs. The Secretary of HHS is also authorized to establish a management information system for IHS. CBO has not included an estimate for these new activities as Committee staff has stated that it is the Committee's intent that funds otherwise appropriated in 1986 through 1989 be redirected to include these activities.

6. Estimated cost to State and local governments: The budgets of state and local governments would not be affected directly by the enactment of this bill.

7. Estimate comparison: None.

8. Previous CBO estimate: CBO prepared an estimate for H.R. 1426 as ordered reported by the House Committee on Interior and Insular Affairs, on May 3, 1985. We also prepared an estimate for S. 277 as ordered reported by the Senate Select Committee on Indian Affairs, on May 15, 1985. All of these bills amend the Indian Health Care Improvement Act, but provisions in the bills differ.

9. Estimate prepared by: Carmela Pena.

10. Estimate approved by C.G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

Inflationary Impact Statement

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee states that, in its view, the bill would have no inflationary impact on the economy. The funds authorized to be appropriated under the proposed legislation represent an insignificant share of the budget of only one department of the Federal Government. To the extent that the funds made available under this bill prevent serious illness among the American Indian and Native Alaska population, and thereby obviate the need for more expensive treatment at Federal, State, or private expense, the effect of the bill would be anti-inflationary.

Agency Views

Department of Health and Human Services,
Office of the Secretary,
Washington DC, May 17, 1985.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Department has not completed a formal report on H.R. 1426, the "Indian Health Care Amendments of 1985", as ordered reported by the Committee on Energy and Commerce on May 15. In lieu thereof, I would appreciate inclusion in the Committee's report of our views as expressed in the attached statement of Dr. Robert Graham, Administrator, Health Resources

and Services Administration, before the Subcommittee on Health and the Environment on March 8, 1985.

Sincerely,

LAWRENCE J. DENARDIS,
Acting Assistant Secretary for Legislation.

STATEMENT BY ROBERT GRAHAM, M.D., ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, HOUSE OF REPRESENTATIVES, MARCH 8, 1985

Mr. Chairman and Members of the Committee: I am Dr. Robert Graham, Administrator of the Health Resources and Services Administration. With me is Dr. Everett Rhoades, Director of the Indian Health Service (IHS). I am very pleased to be here today to discuss with you and your Committee the reauthorization of the Indian Health Care Improvement Act, Public Law 94-437. We consider principles embodied by this Act to be the keystone to the continuing goal to raise the health status of the American Indian and Alaska Native people to the highest possible level.

It was Public Law 94-437 which, for the first time, established parity as a benchmark to measure our efforts to reach this goal. It requires the Secretary to assess the programs established or asisted under this Act to determine additional steps necessary to insure that the health status of and the health services available to Indians are "at a parity with the health services available to, and the health status, of the general population". The determination as to what steps are necessary to continue our progress is reflected in the proposed FY 1986 budget.

Mr. Chairman, given the confusion arising from the President's veto of a similar bill last year, I think it might be useful to review briefly the reasons for his veto, to examine the programmatic effects of the veto, and to comment in general terms on the degree to which this bill addresses the concerns raised in the President's Memorandum of Disapproval.

The President withheld his approval of S. 2166 last year for the following reasons: first, he objected to the provision making certain Indians ineligible for certain state and locally provided health care benefits; second, he objected to the unconstitutional mechanism by which the Indian Health Service would be removed from the Health Resources and Services Administration; third, most of the bill's provisions duplicated existing authorities; fourth, the bill would have unnecessarily changed the organizational structure of the Indian Health Service; fifth, the bill would have increased IHS responsibility for services only peripherally related to IHS's primary mission; and sixth, and by no means least, the authorization levels in S. 2166 were excessive.

In his Memorandum of Disapproval, the President made it clear that the veto would have no adverse impact on the ability of the IHS to continue to provide quality health care to American Indians and Alaska Natives. Today over five months into fiscal year 1985, I am pleased to report to you that the broad authority of the Snyder Act has permitted the IHS to continue to provide its entire complement of health care and health care-related services.

In the context of the President's veto message, let me comment briefly on H.R. 1426. We applaud removal of the two provisions regarding Indians' eligibility for State and locally-provided health care benefits and the unconstitutional transfer mechanism. However, the bill retains a number of objectionable features. In general terms, the bill retains duplicative authorities, unnecessarily interferes with the origanizational structure of the Department of Health and Human Services, inappropriately expands IHS responsibility into areas only indirectly related to primary health care delivery, and contains excessive authorization levels.

The Indian Health Care Improvement Act is a keystone of our overall efforts. The Act is designed to maintain a health care system which provides high quality health services to the Indian people. Increases in financial and human resorces are aimed at strengthening an infrastructure capable of meeting the natinal goal of raising the health status of the Indian people to the highest possible level and of encouraging the maximum participation of the Indian people in the planning and management of these health systems.

The primary method provided by Congress for the Indian people to exercise maximum participation in the management of these health systems was the Indian Self-Determination Act, Public Law 93-638, which provides tribal governments with the right to take over the operation of most Indian Health Service programs serving them. Nevertheless, the Congress saw that the health systems serving Indians should meet the standards available to the general population before it would be feasible for tribes to assume control. The Indian Health Care Improvement Act was the method chosen by the Congress to bring the Indian health system up to a level comparable to the general population and thus position those tribes, which so chose, to utilize Public Law 93-638.

The linkage between Public Law 94-437 and Public Law 93-638 does not mean that the two laws are totally interdependent. Public Law 93-638 goes byond health care and addresses the issue of tribal sovereignty. Consequently, we recommend that issues involving Indian Self-Determination not be considered as part of the reauthorization of Public Law 94-437. In addition to clouding health care issues, we believe that all the tribes deserve the opportunity to consider changes affecting Indian Self-Determination

in a forum that has self-determination as its prime, if not its only, purpose.

We are concerned about including in an Indian health improvement bill any provisions that go beyond establishing health improvement goals. I speak particularly about a number of provisions that deal with California. Those California provisions that would amend Public Law 93-638 should be addressed separately and not in the context of Public Law 94-437. In addition, however, we are opposed to the provision in section 705 that would provide a separate and special legislative definition of California Indian eligibility for IHS services. We recognize that there are unique problems in California, but we do not believe those problems center around the definition of eligibility for IHS programs nor that it would be wise to attempt to correct a localized historical problem in legislation aimed at a nationwide program.

The Indian Health Care Improvement Act, in conjunction with the Indian Self-Determinatin Act, represents almost a decade of effort to establish a framework within which Indian people can effectively participate in deciding their role in health programs developed to serve the Indian community.

To achieve the intent of the Congress, the IHS, within the framework of self-determination and the provisions of this law, established three precepts:

1. Continue improvement of health programs for Indians in ways that expedite health status elevation and result in health delivery systems which lend themselves to successful local management.

2. Maximize the American Indian and Alaska Native awareness of and participation in all health programs for which they are eligible on the same basis as all others who qualify; and maximize those programs' awareness of the need and efficacy of special efforts to make benefits available and accessible to the American Indians and Alaska Natives.

3. Accelerate development of Indian communities' capacities to staff and manage their own health programs to such extent as they may choose.

During the period that these precepts have been in force, significant improvements in the health status of Indians have been achieved. Nevertheless, disparity remains in the health status of Indians when compared to that of the U.S. general population. Mortality is still 7% higher than that of the U.S. white population, based on 1982 age-adjusted rates.

With the foregoing concerns in mind, the Department has developed a legislative proposal which we believe clearly focuses on the goals of Public Law 94-437.

I would like to now turn to some of the specifics contained in H.R. 1426.

Title I, Indian Health Manpower, should be extended for three years but authorize only such funds as may be neces-

sary to fund students who had been funded by October 1, 1985. Though the Department does not support the awarding of new scholarships, the Department does agree that the goal of the Indian Health Scholarship program would be further strengthened by the proposal permitting service in projects operated under the Indian Self-Determination Act to be added as a payback option. This would strengthen self-determination efforts. The proposed language in section 103 of the bill, however, does not clearly permit the service obligation to be satisfied by direct employment by a Public Law 93-638 contractor.

The Department does not believe there is any need for the proposed section 105(d) of the Act that would restrict stipend payments when students are working for IHS under the section 105 Extern Program. Stipend payments for "Health Professional Preparatory Scholarship" recipients (section 103) are already limited to periods when the recipients are attending school full time. In addition, the Department is opposed to applying this restriction to Indian Health Scholarship recipients (section 104 i.e. sec. 338G of the PHS Act) since this would treat them differently from other National Health Service Corps Scholarships recipients and act as a disincentive to their working for IHS during non-academic periods. Under the proposal, such students would be entitled to retain their stipend if they worked for someone other than IHS. There are immediate and long term career benefits accruing to IHS and its service population by encouraging these scholarship recipients to work for IHS during non-academic periods.

The proposed section 201, Health Services, has excessive reporting requirements along with required procedures which would place a tremendous administrative burden on IHS and the Indian tribes. The proposal mixes health care improvement, fixed priorities, planning, and equity issues into a single process which we believe is counter productive. Instead, the Department recommends that, rather than expand the current categorical structure of Title II, Health Services, a single amount be authorized for funds to be directed at health service needs.

The proposed new section 201(b)(2) deals with Public Law 93-638 contracts establishing a limit of 15% on Public Law 93-638 funds which can be used for health planning, training, technical assistance and administrative support functions. It is unclear if the restriction applies to the contractor, to IHS, or to both. If administrative support functions include expenses generally covered by indirect costs, we are concerned that Public Law 93-638 contractors would be limited to a 15% indirect cost rate.

The Department supports the extension of the authority to expand funds for research contained in the proposed new section 201(e), but opposes authorizing such research under Public Law 93-638 contracts which, because of their mandatory nature, are not suitable instruments for research contracts which must be with entities that already

have the needed expertise to address the subject being researched.

The Department does not believe a separate and additional authorization (as proposed by section 202 of H.R. 1426) is required to establish a Catastrophic Health Emergency Fund to deal with extraordinarily expensive illnesses or accidents occurring to Indians served by either IHS or IHS funded programs.

The IHS, as a health system, is able to shift available resources to cover these incidents. The Department supports in principle the effort to rationalize and institutionalize the current IHS efforts to deal with this increasingly important problem.

The Department does not believe the competitive bidding for health services is a problem under the implementation policies and procedures currently in place. The Department has the authority to waive the competitive bidding process when necessary and its policies and procedures reflect this authority. Therefore, the Department does not believe there is any need for authority to waive competitive procurement as provided in section 203 of the bill. Moreover, the Department opposes the provision that would require the Secretary to waive competitive bids simply on the basis of a certification from the responsible "Chief Medical Officer" that accessibility, quality, or continuity of care would be endangered.

We support a simple extension of the existing section 301 of the Indian Health Care Improvement Act, Construction and Renovation of Service Facilities, rather than the version contained in H.R. 1426 which we believe has excessive reporting requirements and inappropriate administrative provisions. The President's FY 1986 budget requests no funds for construction of new service facilities. In considering the FY 1987 budget, the Administration will reevaluate without prejudice any IHS plan to construct new service facilities.

We believe there is a particular problem with the proposed new section 301(d) dealing with the closures of facilities. Any provision governing closures should permit waiver of the one year notice where good cause exists, either fiscal or medical. We also recommend that any such provision not apply to temporary closures or to closures of a portion of a facility. Specific services representing a portion of a facility must periodicially be curtailed or closed because of a multitude of reasons such as changing medical procedures, and changing demographics and other factiors that would alter the demand on health services. The provision, as drawn, is far too broad in scope and would adversely affect the IHS management of the facilities.

With regard to section 302 of Public Law 94-437, Construction of Safe Water and Sanitary Waste Disposal Facilities, we support amending the section to permit the Indian Health Service to continue to administer funds made available under other appropriations for the con-

struction of sanitation facilities. The Administration is requesting no direct Indian Health Service appropriations for the construction of sanitation facilities in FY 1986, but recognizes that IHS expertise in this area could be useful to other agencies responsible for Indian housing.

In addition, the Department opposes language in the proposed new subsection 302(d) that would result in IHS constructing and operating sanitation systems for tribes that the Secretary has determined do not have, and can not reasonably be expected to develop, the necessary technical capacity to operate systems on their own. The IHS has been very successful, and is expected to continue to be successful, in assisting tribes in developing the competence necessary to operate and maintain sanitation facilities. The percentage of systems in place and operating at an acceptable level of competence compares very favorably with rural systems run by the general population.

The local control and responsibility of tribes and Indian communities to operate and maintain the water and sanitation systems has been one of the major strengths and sources of success of the program. The proposal would act as a disincentive to tribes currently doing a responsible job.

Section 303 of the bill would permit the use of certain non-IHS funds to renovate IHS facilities under prescribed conditions. This same provision is contained in the Fiscal Year 1985 Appropriations Act, Public Law 98–473. The Department supports this provision, because it furthers both Indian self-determination and the Department's policy to utilize alternate resources wherever appropriate.

The Department supports extension of section 404 which authorizes grants and contracts with tribal organizations to improve Indian access to the Medicare and Medicaid programs. This provision would be supportive of the Department's efforts to increase third party payments for Indian health.

The Department strongly opposes the proposed extension of Title V of the Indian Health Care Improvement Act, Health Service for Urban Indians, and no funds are requested for this purpose in the President's budget for FY 1986. Existing State and community based health organizations currently absorb most of the clinical workload of the urban Indian projects. These projects have demonstrated their ability to generate revenue from other sources. Reduction of direct Federal support should not drastically change the ability of the community to provide linkages that have established by the urban Indian projects and the funds being generated from other sources by these projects.

Section 601 of the bill would establish an Office of Indian Health Affairs in the Office of the Secretary of Health and Human Services. The IHS would be transferred to the new Office, which would report to the Secretary. The Department sees no advantages in removing the

IHS from the Public Health Service. We believe the Indian Health Service should be located within the Public Health Service in order to take advantage of the available health expertise. We therefore oppose section 601. The rationale for the 1955 transfer of Indian health responsibility from the Bureau of Indian Affairs to the Public Health Service was that Indian health would be improved if responsibility were located in the Public Health Service. Given the significant improvement in Indian health over the past thirty years, we believe that promise is still valid. Given our concerns about moving IHS from the PHS, we cannot support section 601 of this bill.

There are strong in support of IHS remaining a component of the Health Resources and Services Administration. We have made major strides toward our goal of providing the highest possible health status to the Indian people and Alaska Natives. We believe that the present organizational structure enhances this effort, and the allegation that IHS is not sufficiently visible or that it does not have enough access to Department leadership is unfounded. It is the largest bureau within HRSA. HRSA also administers most of the health services delivery programs of this Department including the National Health Service Corps, many of whose members are recruited for, and serve in, the IHS. To disturb the existing good working relationships among these programs could impede the progress of IHS rather than accelerate it. We do not think it would be in the best interest of Indian health to be locked into a specific legislative solution without first a careful consideration of the above concerns. We therefore oppose section 601.

The Department opposes section 701 of the bill which would amend section 704, of the Indian Health Care Improvement Act, Leases with Indian Tribes, as we believe it would result in excessive payments for property leased from tribes in that IHS might have to pay for depreciation even where the funds for construction of the property were provided by the Federal government. In addition the proposed new section 704(b)(3) could require IHS to make payments for facilities it owned. We believe the cost principles applicable to all other entities leasing property to the Federal government are adequate and that there is no justification for special principles applicable only to Indian tribes.

The Department supports the intent of section 702 of H.R. 1426 which would initiate a program aimed at alcohol and drug abuse among Indian youth. Juvenile alcohol and drug abuse has reached epidemic proportions in many Indian communities. The problems are such that the interagency cooperation called for in the proposal is essential if any success is to be achieved. We believe, however, that legislation is not needed to accomplish the goals of this section. In any event, the time frame to enter into an interagency agreement is unrealistic and does not allow sufficient time to assure full consideration of the needs of

such an agreement. Finally, we oppose the statutory establishment of an Office of Alcohol and Drug Abuse with a mandated organizational structure, and believe that such decisions are better handled administratively.

The Department opposes section 703 of the bill which would authorize a study of nuclear resources development health hazards on Indians and Indian miners. Such a study was called for by section 707 of the current law, has been completed and was submitted to the Congress on April 27, 1983. The Department does not believe there is a need for further study of the health hazards of nuclear development activities on or near Indian reservations. Numerous studies have been conducted concerning abandoned uraniun mill tailings piles located on Indian land and remedial action begun where appropriate. While a concern, the risk of cancer developing from background radiation in uranium mining or milling occupations in extremely small and other health problems exist on Indian land which pose considerably more risk to the Indian population than radiation. In addition, "A Plan for Diagnosis and Prevention of Illness Related to Nuclear Resources Development on Indian Land" was developed in accordance with section 707(b) and was forwarded to Congress on June 18, 1984.

Section 704 of the bill would authorize funds for an additional four years for Arizona as a Contract Health Service Delivery Area (CHSDA) but would cover only members of Federally recognized tribes of Arizons. Because there are administrative procedures in place by which Arizona could be designated as a single CHSDA, specific legislation is not required to permit such a result. In addition, the restriction of contract health service eligibility only to members of tribes located in the Arizona CHSDA would differ from the eligibility criteria in the other CHSDAs. For this reason, the Department opposes section 704.

The Department opposes section 705 of the bill which provides a special definition of California Indian eligibility and recommends that, instead, the provisions in the current section 709 be extended but limited to those individuals who were members of federally recognized tribes in California at the time their federal recognition was terminated. We recognize that there are unique problems in California, but we do not believe these problems center around the definition of eligibility for IHS programs.

The Department does not oppose the designation of a single contract health service delivery area (CHSDA) for California as provided in section 706 of the bill, but believes it should include only counties that are currently in either a CHSDA or an IHS service area. The bill, as written, would add eleven counties to the IHS service area and increase the potential service population, based on projections of census figures, by almost 30,000 people.

The Department opposes section 707 of the bill which, in proposed section 711(a), provides that funds will be provid-

ed to direct operations and to Public Law 93-638 contract programs on the same basis. This is already IHS policy and practice and is required by both the law and the regulations to the extent later appropriation act permit. Inclusion of section 711(a) would set up false expectations since later enacted appropriation language will continue to govern.

The Department also opposes that portion of section 707 of the bill which gives non-tribal Indians in California the right to out of a Public Law 93-638 contract if 51% of the affected adults so desire. We believe this could add further devisiveness to the California situation and undermine Public Law 93-638. Without being able to serve the total service population, a tribe might not be able to contract under Public Law 93-638 because of the indivisibility of the function or the need for a population sufficiently large so as to justify the contract. In addition, we are very concerned taht this would lead to increased litigation because of the many ambiguous aspects of the proposal, e.g., how do you determine whether an organization represents 51% of the non-tribal Indians, and that the required percentage of adult non-tribal Indians does, in fact, object to the proposal. We believe the provision would permit any group claiming to represent 51% on non-tribal Indians to block many Public Law 93-638 contracts in California. The IHS could, of course, contract with a Public Law 93-638 contractor to serve non-tribal Indians under the Buy Indian Act but this would represent a virtual duplication of administrative effort and a waste of resources.

The Department also opposes Section 708 of the bill which would retroactively prohibit the removal of National Health Service Corps (NHSC) members from IHS and Public Law 93-638 programs unless is is ensured that there would be no reduction in services. This cannot be accomplished retroactively and would be counter to any system aimed at ranking needs and directing resources to whatever the greatest need exists.

The Department suggests the following conditions be added to the section 709 proposal which would authorize IHS to provide medical care in its facilities to various classes of people who are not otherwise eligible for IHS services: (1) The Department supports opening facilities to the general public only at remote facilities and only if the State or local governments involved agree to cover the cost of care provided to the non-Indian medically indigent; and (2) any monies collected by the IHS for the care and treatment of patients, both beneficiaries and non-beneficiaries, as well as money recovered through subrogation of patient claims, including money recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2641-53), for care and treatment paid for or provided by the IHS should reimburse the account of the IHS and should remain available until expended.

Finally, we believe that multi-tribal service areas that have opened IHS facilities to the non-Indian community based on the concurrence of all affected tribes should not be closed to the non-Indian community unless at least half the affected tribes revoke their concurrence.

The proposed new Section 714 would prohibit the IHS from putting any restriction on a contractor's use of program income including lobbying and litigation against the Federal government. The IHS frequently does not off-set a contractor's program income when determining the funding level. This waiver of normal Departmental policy is granted in exchange for the Contractor's agreement that it will use program income only for furtherance of the contract's purpose. Should section 714 become law, this waiver policy would have to be reviewed with the aim of assuring the maximum amount of health care for the funds available. We do not believe the proposed section 714 is in the best interest of either the Federal government or the Indian people as it will result in a decrease in the total resources used by contractors for health care. Therefore we oppose it.

Reduction of Indian infant morality has and continues to be of the highest priority for the IHS and the Department as demonstrated by the fact that the Indian infant mortality rate in 1980–82 is 11.9—equal to the U.S. All Races rate for 1981. While we support the intent of the proposed new section 715, to lower Indian infant and maternal mortality to a rate no greater than that of the general popluation, we do not support the mechanism proposed. Indian infant mortality for the neonatal period (up to 28 days after birth) is actually lower than for the general population. However, after this period, when the child has left the hospital and returns to the home, the Indian infant mortality rate rises above that of the general population. The ability to affect the rate during this latter period requires a much more complex intervention approach involving not only health care but also environmental, economic and cultural influences. The IHS should not be given the sole responsibility for ameliorating a problem which has considerable non-health aspects.

The maternal mortality rate for American Indians and Alaska Natives residing in the Reservation States for 1980–82 was 7.5 per 100,000 live births. This was lower than the U.S. All Races rate for 1981 of 8.5. There have been relatively few reported Indian maternal deaths in the Reservation States over the past decade, i.e., ranging from one to four deaths per year.

Because of these complexities, the Department does not believe that a specific five year program would be the most effective use of scarce resources. Instead, the Department recommends continued support of ongoing efforts to reduce infant morbidity as well as mortality.

The proposed new Section 716 would enlarge the CHSDA for the Turtle Mountain Band of Chippewa Indi-

ans by the addition of Divide, McKenzie, and Williams Counties of North Dakota and Richland, Roosevelt, and Sheridan Counties in Montana to the current CHSDA and limit eligibility for contract health services to tribal members. We have seen no justification for such a legislative deviation from the "on or near" a reservation criteria the Congress makes applicable to other tribes. There are administrative procedures in place by which a CHSDA can be redesignated taking into account the tribal situation and available resources.

This concludes my opening statement. We will be glad to answer any questions you may have.

Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Indian Health Care Improvement Act

* * * * * * *

DEFINITIONS

Sec. 4. For purposes of this Act—

(a) "Secretary", unless otherwise designated, means the Secretary of Health and Human Services.

* * * * * * *

[(i) "Rural Indian" means any individual who resides in a rural community as defined in subsection (j), who is an Indian within the meaning of subsection (c), and who is not otherwise eligible to receive health services from the Service.

[(j) "Rural Community" means any community that—

[(1) is not located on a Federal Indian reservation or trust area;

[(2) is not an Alaskan native village;

[(3) is not an urban center; and

[(4) has a sufficient rural Indian population with unmet health needs, as determined by the Secretary, to warrant assistance under Title V of this Act.

[(k) "Rural Indian organization" means a nonprofit corporate body governed by a board of directors controlled by rural Indians and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).]

(i) "Area Office" means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographical area; and

(j) "Service Unit" means an administrative entity within the Indian Health Service or a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act through which services are provided, directly and by contract, to the eligible Indian population within a defined geographic area.

(k) "Native Hawaiian" means any individual who has any ancestors that were natives, prior to 1778, of the area that now comprises the State of Hawaii.

(l) "Native American Pacific Islander" means—

(1) any Native Hawaiian,

(2) any of the indigenous people residing in Guam, American Samoa, the Trust Territory of the Pacific Islands, or the Northern Mariana Islands; or

(3) any individual whose direct ancestors are from Guam, American Samoa, the Trust Territory of the Pacific Islands, or the Northern Mariana Islands.

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TITLE I—INDIAN HEALTH MANPOWER

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HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS

SEC. 102. (a) * * *

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[(c) For the purpose of making payments pursuant to grants under this section, there are authorized to be appropriated $900,000 for fiscal year 1978, $1,500,000 for fiscal year 1979, and $1,800,000 for fiscal year 1980. There are authorized to be appropriated to carry out this section $2,300,000 for the fiscal year ending September 30, 1981, $2,600,000 for the fiscal year ending September 30, 1982, $3,000,000 for the fiscal year ending September 30, 1983, and $3,500,000 for the fiscal year ending September 30, 1984.]

(c) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $550,000 for fiscal year 1986,

(2) $600,000 for fiscal year 1987,

(3) $650,000 for fiscal year 1988, and

(4) $700,000 for fiscal year 1989.

HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS

SEC. 103. (a) * * *

* * * * * * *

(c) Scholarship grants made under this section may cover costs of tuition, books, transportation, board, and other necessary related expenses *of a grantee while attending school full time.*

[(d) There are authorized to be appropriated for the purpose of this section: $800,000 for fiscal year 1978, $1,000,000 for fiscal year 1979, and $1,300,000 for fiscal year 1980. There are authorized to be appropriated to carry out this section $3,510,000 for the fiscal year

ending September 30, 1981, $4,000,000 for the fiscal year ending September 30, 1982, $4,620,000 for the fiscal year ending September 30, 1983, and $5,300,000 for the fiscal year ending September 30, 1984.]

(d) The Secretary shall not deny scholarship assistance to an eligible applicant under this section solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution.

(e) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $4,000,000 for fiscal year 1986,
(2) $4,700,000 for fiscal year 1987,
(3) $5,400,000 for fiscal year 1988, and
(4) $6,100,000 for fiscal year 1989.

[HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

[Sec. 104. Section 225(i) of the Public Health Service Act (42 U.S.C. 234(i) is amended (1) by inserting "(1)" after "(i)", and (2) by adding at the end the following:

[(2)(A) In addition to the sums authorized to be appropriated under paragraph (1) to carry out the Program, there are authorized to be appropriated for the fiscal year ending September 30, 1978, $5,450,000; for the fiscal year ending September 30, 1979, $6,300,000; for the fiscal year ending September 30, 1980, $7,200,000; and for fiscal years 1981, 1982, 1983, and 1984 such sums as may be specifically authorized by an Act enacted after the Indian Health Care Improvement Act, to provide scholarships under the Program to provide physicians, osteopaths, dentists, veterinarians, nurses, optometrists, podiatrists, pharmacists, public health personnel, and allied health professionals to provide services to Indians. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with this section except as provide in subparagraph (B).

[(B)(i) The Secretary, acting through the Indian Health Service, shall determine the individuals who receive the Indian Health Scholarships, shall accord priority to applicants who are Indians, and shall determine the distribution of the scholarships on the basis of the relative needs of Indians for additional service in specific health professions.

[(ii) The active duty service obligation prescribed by subsection (e) shall be met by the recipient of an Indian Health Scholarship by service in the Indian Health Service, in a program assisted under title V of the Indian Health Care Improvement Act, or in the private practice of his profession if, as determined by the Secretary in accordance with guidelines promulgated by him, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

[(C) For purposes of this paragraph, the term 'Indians' has the same meaning given that term by subsection (c) of section 4 of the Indian Health Care Improvement Act and includes individuals described in clauses (1) through (4) of that subsection.".]

INDIAN HEALTH PROFESSIONS SCHOLARSHIPS

[*SEC. 104. (a) In order to provide health professionals to Indian communities, the Secretary, acting through the Service and in accordance with this section, shall make scholarship grants to Indians who are enrolled full time in schools of medicine, osteopathy, dentistry, veterinary medicine, nursing, optometry, public health, and allied health professions. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section 338A of the Public Health Service Act (42 U.S.C. 254) except as provided in subsection (b) of this section.*

(b)(1) The Secretary, acting through the service, shall determine who shall receive such scholarships and shall determine the distributon of such scholarships among such health professions on the basis of the relative needs of Indians and, subject to available appropriations, Native Hawaiians for additional service in such health professions.

(2) An individual shall be eligible for a scholarship under subsection (a) in any year in which such individual is enrolled full time in a health profession school referred to in subsection (a).

(3) The active duty service obligation prescribed under section 338B of the Public Health Service Act (42 U.S.C. 254m) shall be met by a recipient of an Indian Health Service, including service under a contract under the Indian Self-Determination Act (Public Law 93-638); in a program assisted under title V of this Act; or in the private practice of his profession if, as determined by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

(c) For the purpose of this section, the term "Indian" has the same meaning given that term by subsection (c) of section 4 of the Act, including all individuals described in clauses (1) through (4) of this Act, including all individuals described in clause (1) through (4) of this subsection.

(d) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $6,100,000 for fiscal year 1986,
(2) $7,000,000 for fiscal year 1987,
(3) $8,100,000 for fiscal year 1988, and
(4) $9,234,000 for fiscal year 1989.

INDIAN HEALTH SERVICE EXTERN PROGRAMS

SEC. 105. (a) Any individual who receives a scholarship grant pursuant to section 757 of the Public Health Service Act shall be entitled to employment in the service during any nonacademic period of the year. Periods of employment pursuant to this subsection shall not be counted in determining the fulfillment of the service obligation incurred as a condition of the scholarship grant.

* * * * * * *

[(d) There are authorized to be appropriated for the purpose of this section: $600,000 for fiscal year 1978, $800,000 for fiscal year 1979, and $1,000,000 for fiscal year 1980. There are authorized to be approriated to carry out this section $990,000 for the fiscal year

ending September 30, 1981, $1,140,000 for the fiscal year ending September 30, 1982, $1,310,000 for the fiscal year ending September 30, 1983, and $1,510,000 for the fiscal year ending September 30, 1984.]

(d) No stipend may be paid to any person under section 103 or 104 while such person is employed under this section.

(e) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $300,000 for fiscal year 1986,
(2) $350,000 for fiscal year 1987,
(3) $400,000 for fiscal year 1988, and
(4) $450,000 for fiscal year 1989.

CONTINUING EDUCATION ALLOWANCES

SEC. 106. (a) In order to encourage physicians, dentists, and other health professionals to join or continue in the Service and to provide their services in the rural and remote areas where a significant portion of the Indian people resides, the Secretary, acting through the Service, may provide allowances to health professionals employed in the Service to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation and refresher training courses.

[(b) There are authorized to be appropriated for the purpose of this section: $100,000 for fiscal year 1978, $200,000 for fiscal year 1979, and $250,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to be appropriated for the purpose of this section such sums as may be specifically authorized by an Act enacted after this Act.]

(b) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $500,000 for fiscal year 1986,
(2) $526,300 for fiscal year 1987,
(3) $553,800 for fiscal year 1988, and
(4) $582,500 for fiscal year 1989.

TITLE II—HEALTH SERVICES

HEALTH SERVICES

[SEC. 201. (a) For the purpose of eliminating backlogs in Indian health care services and to supply known, unmet medical, surgical, dental, optometrical, and other Indian health needs, the Secretary is authorized to expend, through the Service, over the seven-fiscal-year period beginning after the date of the enactment of this Act the amounts authorized to be appropriated by subsection (c). Funds appropriated pursuant to this section for each fiscal year shall not be used to offset or limit the appropriations required by the Service under other Federal laws to continue to serve the health needs of Indians during and subsequent to such seven-fiscal-year period, but shall be in addition to the level of appropriations provided to the Service under this Act and such other Federal laws in the preceding fiscal year plus an amount equal to the amount required to cover pay increases and employee benefits for personnel employed

under this Act and such laws and increases in the costs of serving the health needs of Indians under this Act and such laws, which increases are caused by inflation.

[(b) The Secretary, acting through the Service, is authorized to employ persons to implement the provisions of this section during the seven-fiscal-year period in accordance with the schedule provided in subsection (c). Such positions authorized each fiscal year pursuant to this section shall not be considered as offsetting or limiting the personnel required by the Service to serve the health needs of Indians during and subsequent to such seven-fiscal-year period but shall be in addition to the positions authorized in the previous fiscal year.

[(c) The following amounts and positions are authorized, in accordance with the provisions of subsections (a) and (b), for the specific purposes noted:

[(1) Patient care (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $8,500,000 and two hundred and twenty-five positions for fiscal year 1979, and $16,200,000 and three hundred positions for fiscal year 1980. There are authorized to be appropriated $20,250,000 for the fiscal year ending September 30, 1981, $23,000,000 for the fiscal year ending September 30, 1982, $26,500,000 for the fiscal year ending September 30, 1983, and $30,500,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(2) Field health, excluding dental care (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $3,350,000 and eighty-five positions for fiscal year 1979, and $5,500,000 and one hundred and thirteen positions for fiscal year 1980. There are authorized to be appropriated $6,400,000 for the fiscal year ending September 30, 1981, $7,350,000 for the fiscal year ending September 30, 1982, $8,450,000 for the fiscal year ending September 30, 1983, and $9,700,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(3) Dental care (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $1,500,000 and eighty positions for fiscal year 1979, and $1,500,000 and fifty positions for fiscal year 1980. There are authorized to be appropriated $1,875,000, for the fiscal year ending September 30, 1981, $2,150,000 for the fiscal year ending September 30, 1982, $2,500,000 for the fiscal year ending September 30, 1983, and $2,875,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(4) Mental health: (A) Community mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $1,300,000 and thirty positions for fiscal year 1979, and $2,000,000 and thirty positions for fiscal year 1980. There are authorized to be appropriated $2,500,000 for the fiscal year ending September 30, 1981, $2,875,000 for the fiscal year ending September 30, 1982, $3,300,000 for the fiscal year

ending September 30, 1983, and $3,800,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(B) Inpatient mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $400,000 and fifteen positions for fiscal year 1979, and $600,000 and fifteen positions for fiscal year 1980. There are authorized to be appropriated $750,000 for the fiscal year ending September 30, 1981, $870,000 for the fiscal year ending September 30, 1982, $1,000,000 for the fiscal year ending September 30, 1983, and $1,150,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(C) Model dormitory mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $1,250,000 and fifty positions for fiscal year 1979, and $1,875,000 and fifty positions for fiscal year 1980. There are authorized to be appropriated $2,350,000 for the fiscal year ending September 30, 1981, $2,700,000 for the fiscal year ending September 30, 1982, $3,100,000 for the fiscal year ending September 30, 1983, and $3,600,000 for the fiscal year ending September 30, 1984, and such further positions are authorized as may be necessary for each such fiscal year.

[(D) Therapeutic and residential treatment centers: sums and positions as provided in subsection (e) for fiscal year 1978, $300,000 and ten positions for fiscal year 1979, and $400,000 and five positions for fiscal year 1980. There are authorized to be appropriated $460,000 for the fiscal year ending September 30, 1981, $525,000 for the fiscal year ending September 30, 1982, $600,000 for the fiscal year ending September 30, 1983, and $690,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(E) Training of traditional Indian practitioners in mental health: sums as provided in subsection (e) for fiscal year 1978, $150,000 for fiscal year 1979, and $200,000 for fiscal year 1980. There are authorized to be appropriated $250,000 for the fiscal year ending September 30, 1981, $285,000 for the fiscal year ending September 30, 1982, $325,000 for the fiscal year ending September 30, 1983, and $375,000 for the fiscal year ending September 30, 1984.

[(5) Treatment and control of alcoholism among Indians: $4,000,000 for fiscal year 1978, $9,000,000 for fiscal year 1979, and $9,200,000 for fiscal year 1980. There are authorized to be appropriated $16,500,000 for the fiscal year ending September 30, 1981, $19,000,000 for the fiscal year ending September 30, 1982, $22,000,000 for the fiscal year ending September 30, 1983, and $25,100,000 for the fiscal year ending September 30, 1984.

[(6) Maintenance and repair (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $3,000,000 and twenty positions for fiscal year 1979, and $4,000,000 and thirty positions for fiscal year 1980. There are authorized to be appropriated $5,000,000 for the fiscal year

ending September 30, 1981, $5,750,000 for the fiscal year ending September 30, 1982, $6,600,000 for the fiscal year ending September 30, 1983, and $7,600,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(d) The Secretary, acting through the Service, shall expend directly or by contract not less than 1 per centum of the funds appropriated under the authorizations in each of the clauses (1) through (5) of subsection (c) for research in each of the areas of Indian health care for which such funds are authorized to be appropriated.

[(e) For fiscal year 1978, the Secretary is authorized to apportion not to exceed a total of $10,025,000 and 425 positions for the programs enumerated in clauses (c) (1) through (4) and (c)(6) of this section.]

INDIAN HEALTH CARE IMPROVEMENT FUND

SEC. 201. (a)(1) To further implement the national policy of raising the health status of Indians to a zero level of deficiency as defined in subsection (c) by eliminating backlogs in health care services and meeting unmet Indian health needs as soon as possible and in an equitable manner, the Secretary is authorized to expend, through the Service, over the four-year period beginning with fiscal year 1986 the amounts authorized to be appropriated by subsection (h) of this section. Funds requested under this section shall be separately stated in the Service budget request as submitted to Congress under section 1104 of title 31, United States Code, and funds appropriated under this section shall not be used to offset or limit appropriations made to the Service under authority of the Act of November 2, 1921 (25 U.S.C. 13), or any other law. Funds appropriated under this section in any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

(2) Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor is it intended to discourage the Service from undertaking additional efforts to achieve parity among tribes.

(b)(1) Funds appropriated under this section shall be expended to augment the ability of the Service to meet the following health service responsibilities—

(A) clinical care (direct or indirect);

(B) preventive health;

(C) dental care (direct or indirect);

(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional Indian practitioners;

(E) emergency medical services;

(F) treatment and control of, and rehabilitative care related to, alcoholism among Indians;

(G) accident prevention programs;

(H) community health representative programs; and

(I) maintenance and repair.

(2) Where any funds allocated to a tribe or service unit are used for a contract under the Indian Self-Determination Act, or a reasonable proportion of such funds may be used for health planning, training, technical assistance, and other administrative support functions.

(3)(A) To the extent that all or a portion of the funds appropriated under subsection (h) are required to raise tribes which are below a level II deficiency, as defined in subsection (c)(2), to such level, such funds shall not be available for allocation to tribes at or above such level.

(B) Funds appropriated under this section may be allocated on a tribe or service unit basis. If allocated on a service unit basis, such funds shall be used by each service unit to raise the deficiency level of each tribe served by such service unit. Apportionment of a tribe or service unit's allocation of funds among the health service responsibilities listed in paragraph (1) shall be as determined by the Service and the affected Indian tribe or tribes.

(c)(1) Within sixty days of the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress the current health services priority system report of the Service for each tribe or service unit including service units serving newly recognized or acknowledged tribes. Such report shall contain—

(A) the methodology for determining tribal health resources deficiencies; the level of health resources deficiency for each tribe; the amount of funds necessary to raise all tribes below a level II deficiency to a level II deficiency; the amount of funds necessary to raise all tribes below a level I deficiency to a level I deficiency; and the amount of funds necessary to raise all tribes to a zero level of deficiency;

(B) an estimate of—

(i) the amount of health service funds appropriated under the authority of this or any other Act for the preceding fiscal year which is allocated to each service unit and to each tribe; and

(ii) the number of Indians eligible for health services in each service unit and each tribe; and

(C) an evaluation of—

(i) the preventive health, health protection, and health promotion needs of Indians identified in tribal specific health plans;

(ii) the preventive health, health protection, and health promotion services necessary to meet such needs;

(iii) the resources which would be required to enable the Service to provide such services; and

(iv) the resources currently available to the Service which could be used to provide such services.

(2) For purposes of this section, health resources deficiency levels shall be defined as follows:

Level I—0 to 20 percent deficiency,
Level II—21 to 40 percent deficiency,
Level III—41 to 60 percent deficiency,
Level IV—61 to 80 percent deficiency,

Level V—81 to 100 percent deficiency,

(3) The Secretary shall establish by regulation procedures which allow any Indian tribe to petition the Secretary for a review of any determination of health resources deficiency level of such tribe.

(d) Upon enactment of the Indian Health Care Amendments of 1985, the Secretary, acting through the Service, shall take all necessary action, in cooperation with each Indian tribe, to bring current the tribal specific health plans which were developed as a part of the plan required by section 703 of this Act and which formed the basis for such plan in response to the requirements of section 701 of this Act. These plans shall be based upon the methodology submitted under subsection (c), as may be further modified through tribal consultation, and shall form the basis for the health services priority system report to be submitted by the Secretary for fiscal year 1987, 1988, and 1989. Such reports shall be submitted to the Congress not more than thirty days after the submission of the annual budget for such fiscal years to the Congress by the President.

(e) The Secretary, acting through the Service, shall expend directly or by contract, including contracts under the Indian Self-Determination Act (Public Law 93-638), not less than 1 percent of the funds appropriated under subsection (h) for research in the areas of Indian health care set out in subparagraphs (A) through (G) of subsection (b)(1).

(f) Programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination Act shall be eligible for funds appropriated pursuant to subsection (h) on an equal basis with programs that are administered directly by the Indian Health Service.

(g) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each fiscal year a separate statement which specifies the total amount obligated or expended in the most recently completed fiscal year to carry out subsection (d) and to carry out each of the subparagraphs of subsection (b)(1).

(h) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $28,000,000 for fiscal year 1986,

(2) $29,000,000 for fiscal year 1987,

(3) $28,000,000 for fiscal year 1988, and

(4) such sums as may be necessary for fiscal year 1989.

Any funds appropriated under this subsection shall be designated as the "Indian Health Care Improvement Fund".

CATASTROPHIC HEALTH PROGRAM

SEC. 202. (a) There is established an Indian Catastrophic Health Emergency Fund (hereinafter in this section referred to as the "Fund") to be administered by the Secretary, acting through the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses falling within the responsibility of the Service. The Fund shall be administered by the central office of the Service and shall not be allocated, apportioned, or delegated on a service unit or area office basis. Funds appropriated under subsection (c)

shall not be used to offset or limit appropriations made to the Service under authority of the Act of November 2, 1921 (25 U.S.C. 13), or any other law. No part of the Fund or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination Act (Public Law 93–638).

(b) The Secretary shall, through the promulgation of regulations consistent with the provisions of this section—

(1) establish a definition of disasters and catastrophic illnesses for which the cost of treatment, whether provided under contract or directly by the Service, would qualify for payment from the Fund; and which shall provide that a service unit shall not be eligible for reimbursement for the cost of treatment from the Fund until its cost of treating any victim of such catastrophic illness or disaster shall have reached a certain threshold cost which the Secretary shall establish at not less than $10,000 or not more than $20,000;

(2) establish a procedure for the reimbursement of service units or facilities rendering treatment or, whenever otherwise authorized by the Service, the reimbursement of nonservice facilities or providers rendering treatment;

(3) establish a procedure for payment from the Fund where the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

(4) establish a procedure that will assure that no payment shall be made from the Fund to any provider to the extent that the provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible or by which the patient is covered.

(c) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $12,000,000 for fiscal year 1986, and

(2) for each of the fiscal years 1987, 1988, and 1989, such sums as may be necessary to maintain the Fund at $12,000,000.

Funds appropriated under this subsection shall remain available until expended.

(d) By no later than January 1, 1989, the Secretary shall report to Congress on the operation of the Fund. Such report shall include—

(1) the number and nature of disasters and catastrophic illnesses for which reimbursement was sought;

(2) the costs associated with such disasters or illnesses;

(3) the amounts reimbursed by the Fund in connection with such disasters and illnesses;

(4) the effect of the Fund on the ability of service units to meet the health needs of their service populations; and

(5) the Secretary's recommendations regarding the future operation of the Fund.

COMPETITIVE PROCUREMENT

SEC. 203. (a) Notwithstanding any other provision of law, the Secretary, acting through the Service, may waive any statutory or administrative requirement for competitive procurement of health services if, in the judgment of the Chief Medical Officer who will have

jurisdiction over such health services, such competitive procurement would compromise the accessibility, quality, or continuity of health services or would not result in any appreciable competition or savings.

(b) Notwithstanding any other provision of law, the Secretary, acting through the Service, shall reject any bid submitted under any statutory or administrative requirement for competitive procurement of health services upon the certification of the Chief Medical Officer who will have jurisdiction over such health services that acceptance of such bid would compromise the accessibility, quality, or continuity of health services.

PREVENTIVE HEALTH, HEALTH PROTECTION, AND HEALTH PROMOTION

SEC. 204. (a) The Congress finds that—

(1) preventive health, health protection, and health promotion services will—

(A) improve the health and well-being of Indians; and

(b) reduce the expenses for medical care of Indians;

(2) preventive health, health protection, and health promotion services should be provided by the coordinated efforts of Federal, State, local, and tribal governments; and

(3) in addition to the provision of primary health care, the Service should provide preventive health, health protection, and health promotion services to Indians.

(b) The Secretary, acting through the Service, shall—

(1) require, by regulation, that each Indian tribe include within any tribal specific health plan submitted to the Secretary—

(A) an identification of the preventive health, health protection and health promotion needs of such tribe; and

(B) a comprehensive plan for providing such services to such tribe;

(2) develop from tribal specific health plans a comprehensive plan for the provision by the Service of preventive health, health protection, and health promotion services to Indians;

(3) establish a schedule for the provision of such services by the Service; and

(4) provide such services to Indians in accordance with such comprehensive plan and schedule.

TITLE III—HEALTH FACILITIES

[CONSTRUCTION AND RENOVATION OF SERVICE FACILITIES

[SEC. 301. (a) The Secretary, acting through the Service, is authorized to expend over the seven-fiscal-year period beginning after the date of the enactment of this Act the same authorized by subsection (b) for the construction and renovation of hospitals, health centers, health stations, and other facilities of the Service.

[(b) The following amounts are authorized to be appropriated for purposes of subsection (a):

[(1) Hospitals: $67,180,000 for fiscal year 1978, $73,256,000 for fiscal year 1979, and $49,742,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to

be appropriated for hospitals such sums as may be specifically authorized by an Act enacted after this Act.

[(2) Health centers and health stations: $6,960,000 for fiscal year 1978, $6,226,000 for fiscal year 1979, and $3,720,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to be appropriated for health centers and health stations such sums as may be specifically authorized by an Act enacted after this Act.

[(3) Staff housing: $1,242,000 for fiscal year 1978, $21,725,000 for fiscal year 1979, and $4,116,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to be appropriated for staff housing such sums as may be specifically authorized by an Act enacted after this Act.

[(c) Prior to the expenditure of, or the making of any firm commitment to expend, and funds authorized in subsection (a), the Secretary, acting through the Service shall—

[(1) consult with any any Indian tribe to be significantly affected by any such expenditure for the purpose of determing and, wherever practicable, honoring tribal preferences concerning the size, locations, type, and other characteristics of any facility on which such expenditure is to be made; and

[(2) be assured that, wherever practicable, such facility, not later than one year after its construction or renovation, shall meet the standards of the Joint Committee on Accreditation of Hospitals.]

HEALTH FACILITIES

Sec. 301. (a)(1) Within sixty days after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress a report which shall set forth the current health facilities priority system of the Service and which shall include the planning, design, construction, or renovation needs for the ten top priority inpatient care fcilities and the ten top priority ambulatory care facilities together with required staff quarters, the justification for suh priority listings, and the projected cost of such projects. The report shall also include the methodology adopted by the Service in establishing priorities under its health facilities priority system.

(2)(A) Within thirty days of the submission of the annual budget to the Congress by the President for each of the fiscal years 1987, 1988, and 1989, the Secretary shall submit to the Congress a report which complies with the requirements for paragraph (1).

(B) In preparing such report in such fiscal years, the Service shall consult with tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities with funds from the Service under the Indian Self-Determination Act, and shall review the needs of these tribes and tribal organizations for inpatient and outpatient facilities, including their needs for renovation and expansion of existing facilities.

(3) The Service shall use the same criteria for each of the fiscal years 1986, 1987, 1988, and 1989 to evaluate the needs of facilities operated under contract under the Indian Self-Determination Act as

it uses to evaluate the needs of facilities operated directly by the Service in such fiscal years.

(4) The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities which are the subject of a contract for health services entered into under the Indian Self-Determination Act are fully and equitably integrated into the development of the health facility priority system.

(b)(1) All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13), for the planning, design, construction, or renovation of health facilities for the benefit of a tribe or tribes shall be subject to the provisions of sections 103 and 104(b) of the Indian Self-Determination Act: Provided, That the United States shall hold title to any facility constructed under a grant pursuant to section 104(b) of that Act.

(2) Any tribal contractor or grantee shall expend the funds described in paragraph (1) for the purpose for which appropriated pursuant to rules and regulations established by the Secretary for contracting and procurement.

(c) Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for facilities planning and design, construction, or renovation under the Act of November 2, 1921 (25 U.S.C. 13), the Secretary, acting through the Service, shall—

(1) consult with any Indian tribe that would be significantly affected by such expenditure for the purpose of determining and, wherever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made, and

(2) ensure, wherever practicable, that such facility, not later than ove year after its construction or renovation, shall meet the standards of the Joint Commission on Accreditation of Hospitals.

(d) The Secretary shall not close, under any existing authority, any Service hospital or other outpatient health care facility or any portion thereof unless he has submitted to the Congress at least one year prior to the planned closure date an evaluation of the impact of the proposed action which shall include the following factors—

(1) accessibility of alternative health care resources for the service population;

(2) cost effectiveness of the closure;

(3) quality of health care to be provided to the service population after closure;

(4) availability of contract health care funds to maintain current levels of service; and

(5) the views of the Indian tribe or tribes served by such facility on the planned closure.

[CONSTRUCTION OF SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

[SEC. 302. (a) During the seven-fiscal-year period beginning after the date of the enactment of this Act, the Secretary is authorized to expend under Section 7 of the Act, of August 5, 1954 (42 U.S.C. 2004a), the sums authorized under subsection (b) to supply unmet

needs for safe water and sanitary waste disposal facilites in existing and new Indian homes and communities.

[(b) For expenditures of the Secretary authorized by subsection (a) for facilities in existing Indian homes and communities there are authorized to be appropriated $43,000,000 for fiscal year 1978, $30,000,000 for fiscal year 1979, and $30,000,000 for fiscal year 1980. For expenditures of the Secretary authorized by subsection (a) for facilities in new Indian homes and communities the area authorized to be appropriated such sums as may be necessary for fiscal years 1978, 1979, and 1980. For fiscal years 1981, 1982, 1983, and 1984 for expenditures authorized by subsection (a) there are authorized to be appropriated such sums as may be specifically authorized in an Act enacted after this Act.

[(c) Former and currently federally recognized Indian tribes in the State of New York shall be eligible for assistance under this section.]

SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

SEC. 302. (a)(1) Congress finds that—

(A) the provision of safe water supply and sanitary sewage and solid waste disposal systems is primarily a health consideration and function;

(B) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such facilities;

(C) the long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing such facilities and other preventive health measures;

(D) many Indian homes and communities still lack safe water supply and sanitary sewage and sold waste disposal facilities; and

(E) it is in the interest of the United States and it is the policy of the United States that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water supply and sanitary sewage and solid waste disposal facilities as soon as possible.

(2) Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

(b) Beginning in fiscal year 1986, the Secretary, acting through the Service, shall develop and begin implementation of a ten-year plan to provide safe water supply and sanitary sewage and solid waste disposal facilities to existing Indian homes and communities and to new and renovated Indian homes.

(c)(1) Within sixty days of the date of the enactment of the Indian Health Care Amendments of 1985, the Secretary shall report to Congress on the Service's sanitation facilities priority system. The Secretary, in preparing such report, shall uniformly apply the methodology for determining sanitation deficiencies to all Indian tribes. Such report shall identify the methodology for determining sanitation deficiencies; the level of deficiency for each Indian community or tribe;

the amount of funds necessary to raise all communities to a level I deficiency; and the amount of funds necessary to raise all communities or tribes to a zero level of deficiency. For the purpose of such report—

(A) a level I deficiency means a sanitation system which complies with all applicable water supply and pollution control laws and regulations in which the defined deficiencies consist of routine replacement repair, or maintenance needs;

(B) a level II deficiency means a sanitation system which complies with all applicable water supply and pollution control laws and regulations in which the defined deficiencies consist of capital improvements necessary to improve the facilities to meet the needs of the communities for domestic sanitation facilities;

(C) a level III deficiency means a sanitation system which has an inadequate or partial water supply and sewage disposal facility which does not comply with applicable water supply and pollution control laws and regulations or which has no solid waste disposal facility;

(D) a level IV deficiency means a sanitation system which lacks either a safe way water supply system or a sewage disposal system; and

(E) a level V deficiency means the absence of a safe water supply and sewage disposal system.

Any tribe or community which lacks the operation and maintenance capability to meet pollution control laws and regulations shall be deemed to have a level III deficiency.

(2)(A) Within thirty days of the submission of the annual budget to the Congress by the President for fiscal years 1987, 1988, and 1989, the Secretary shall submit a report to the Congress which meets the requirements of paragraph (1).

(B) In preparing such report for each of the fiscal years 1987, 1988, 1999, the Secretary, acting through the Service, shall consult with tribes and tribal organizations including those operating health care programs or facilities under contracts under the Indian Self-Determination Act to determine the sanitation needs of each tribe.

(d)(1) To clarify the powers conferred by subsection (a) of section 7 of the Act of August 5, 1984 (42 U.S.C. 2004a), the Secretary, acting through the Service, is authorized to provide—

(A) financial and technical assistance to Indian tribes and communities in the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities,

(B) ongoing technical assistance and training in the management of utility organizations, and

(C) operation and maintenance assistance for, and emergency repairs to, tribal sanitation facilities when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities in situations where the community, tribe, or family is not financially or technically capable of performing the required emergency repairs with their own resources.

(2)(A) This section is not intended to diminish the primary responsibilities of the Indian family, community, or tribe to establish, col-

lect, and utilize reasonable user fees, or otherwise set aside funding, for the purpose of operation and maintenance of sanitation facilities.

(B) The financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation facility shall not be a precondition for the provision or construction of such facilities and the Secretary may not require a tribe or community to accept a transfer of such facilities where he has determined the tribe or community does not have, or may not be reasonably expected to achieve, such capability.

(e) Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination Act shall be eligible for—

(1) funds appropriated pursuant to subsection (f), and

(2) funds appropriated for the purpose of providing water supply or sewage disposal services,

on an equal basis with programs that are administered directly by the Indian Health Services.

(f)(1) There are authorized to be appropriated for each of the fiscal years 1986, 1987, 1988, and 1989, $5,000,000 for the purpose of providing funds necessary to implement the expanded responsibilities of the Service under subsection (d).

(2) In addition to the amount authorized under paragraph (1), there are authorized to be appropriated for each of the fiscal years 1986, 1987, 1988, and 1989, $850,000 for the purpose of providing thirty new full-time equivalents for the Service which shall be used to carry out the expanded responsibilities of the Service under subsection (d).

* * * * * * *

[AUTHORIZATIONS

[SEC. 305. There are authorized to be appropriated to carry out sections 301 and 302 for the fiscal year ending September 30, 1981, for the fiscal year ending September 30, 1982, for the fiscal year ending September 30, 1983, and for the fiscal year ending September 30, 1984, such sums as may be necessary.]

EXPENDITURE OF NONSERVICE FUNDS FOR RENOVATION

SEC. 305. (a) Notwithstanding any other provision of law, an Indian tribe is authorized to expend—

(1) any funds of such tribe which are not held in trust by the Secretary of the Interior,

(2) upon approval of the Secretary of the Interior, any funds held in trust by the Secretary of the Interior for the benefit of such tribe, and

(3) any funds appropriated under Federal law which are not appropriated to the Secretary for expenditure through the Service, for the purpose of making any major renovation or modernization of any Service facility or of any other Indian health facility operated pursuant to a contract entered into under the Indian Self-Determination Act (including an expenditure for

the planning or designing of such renovation or modernization) if the requirements of subsection (b) are met.

(b) The requirements of this subsection are met with respect to any renovation or modernization if the renovation or modernization—

(1) does not require or obligate the Secretary to provide any additional employees or equipment,

(2) is approved by the appropriate area director of the Service, and

(3) is administered by the Indian tribe in accordance with the rules and regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

(c) A renovation or modernization shall not be authorized by this section if such renovation or modernization would require the diversion of funds appropriated to the Service for any project which has a higher priority under the health facility priority system of the Service.

BETHEL, ALASKA, HOSPITAL

SEC. 306. (a) If a final administrative ruling by the Department of the Interior holds that the Bethel Native Corporation is entitled to conveyance of the title to the real property described in subsection (d)(1) under the Alaska Native Claims Settlement Act, such ruling shall not be subject to judicial review and title to such property shall be conveyed to the Bethel Native Corporation.

(b) The Secretary is authorized, notwithstanding any other provision of law, to enter into an agreement with Bethel Native Corporation for an exchange of the real property described in subsection (d)(1) for—

(1) the lands described in subsection (d)(2), or

(2) any other Federal property which Bethel Native Corporation would have been able to select under the Alaska Native Claims Settlement Act.

(c)(1) If an agreement for the exchange of land is not entered into under subsection (b) by the date that is ninety days after the date of the ruling described in subsection (a), the Secretary shall negotiate the terms of an agreement (which shall be entered into by the Secretary only in accordance with paragraph (3)) under which—

(A) the hospital and housing facilities of the Indian Health Service located on the land described in subsection (d)(1) are to be sold to Bethel Native Corporation at a price which enables the Indian Health Service to recover the actual amount expended in the construction of such hospital and housing facilities, and

(B) such hospital and housing facilities are to be leased at a reasonable rate to the Indian Health Service.

(2) The Secretary shall submit to the Congress any agreement negotiated under paragraph (1).

(3) Any agreement negotiated under paragraph (1) shall be entered into by the Secretary on the date that is ninety days after the date on which such agreement is submitted to the Congress. Notwithstanding any other provision of law, the Secretary is authorized to take any action necessary to implement such agreement after the date on which such agreement is entered into by the Secretary.

(d)(1) The real property referred to in subsection (a) is United States Survey Numbered 4000 other than the lands described in paragraph (2).

(2) The lands referred to in subsection (b)(1) are the lands identified as tracts A and B in the determination AA–18959 of the Bureau of Land Management issued on September 30, 1983, pursuant to the Alaska Native Claims Settlement Act.

(e) Nothing in this section or in any agreement negotiated under subsection (c)(1) shall affect the application of the requirement of section 1905(b) of the Social Security Act that the Federal medical assistance percentage be 100 per centum with respect to services received through the hospital.

TITLE IV—ACCESS TO HEALTH SERVICES

ELIGIBILITY OF INDIAN HEALTH SERVICE FACILITIES UNDER MEDICARE PROGRAM

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SERVICES PROVIDED TO MEDICAID ELIGIBLE INDIANS

SEC. 402. (a) * * *

* * * * * * *

[(b) The Secretary is authorized to enter into agreements with the appropriate State agency for the purpose of reimbursing such agency for health care and services provided in Service facilities to Indians who are eligible for medical assistance under title XIX of the Social Security Act, as amended.

[(c) Notwithstanding any other provision of law, payments to which any facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility) is entitled under a State plan approved under title XIX of the Social Security Act by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of such title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the health facilities of such Service in the United States are in compliance with such conditions and requirements.]

* * * * * * *

GRANTS TO AND CONTRACTS WITH TRIBAL ORGANIZATIONS

SEC. 404. (a) The Secretary, acting through the Service, shall make grants to or enter into contracts with tribal organizations to assist such organizations in establishing and administering programs on or near Federal Indian reservations and trust areas and in or near Alaska Native villages to assist individual Indians to—

(1) enroll under section 1818 of part A and sections 1836 and 1837 of part B of title XVIII of the Social Security Act;

(2) pay monthly premiums for coverage due to financial need of such individual; [and] *or*

(3) apply for medical assistance provided pursuant to title XIX of the Social Security Act.

(b) The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any contract or grant which the Secretary makes with any tribal organization pursuant to this section. Such conditions [shall] *may* include, [but are not limited to,] *as appropriate,* requirements that the organization successfully undertake to—

(1) determine the population of Indians to be served that are or could be recipients of benefits under titles XVIII and XIX of the Social Security Act;

(2) assist individual Indians in becoming familiar with and utilizing such benefits;

(3) provide transportation to such individual Indians to the appropriate offices for enrollment or application for medical assistance; *or*

(4) develop and implement a schedule of income levels to determine the extent of payment of premiums by such organization for coverage of needy individuals; and methods of improving the participation of Indians in receiving the benefits provided pursuant to titles XVIII and XIX of the Social Security Act.

(c) There are authorized to be appropriated $5,000,000 for the fiscal year ending September 30, 1981, $5,750,000 for the fiscal year ending September 30, 1982, $6,615,000 for the fiscal year ending September 30, 1983, [and] $7,610,000 for the fiscal year ending September 30, 1984, *$1,500,000 for the fiscal year ending September 30, 1986, $2,000,000* for the fiscal year ending September 30, 1987, $2,500,000 for the fical year ending September 30, 1988, and *$2,000,000* for the fiscal year ending September 30,1989.

STUDY OF BARRIERS TO MEDICAID PARTICIPATION

SEC. 405. (a) The Secretary shall, in consultation with Indian tribes and tribal organizations, conduct a study of any barriers which may prevent Indians from receiving medical assistance under State plans approved under title XIX of the Social Security Act.

(b) By no later than the date which is one year after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress a report on the study conducted under subsection (a). Such report shall include—

(1) recommendations for legislation which—

(A) would remove any barriers identified in such study which prevent Indians from receiving medical assistance under plans described in subsection (a) and,

(B) would encourage participation by Indians in such plans; and

(2) estimates, by service unit, of—

(A) the number of Indians potentially eligible for medical assistance under such plans, and

(B) the number of Indians receiving medical assistance under such plans.

[TITLE V—HEALTH SERVICES FOR URBAN AND RURAL INDIANS

[PURPOSE

[SEC. 501. The purpose of this title is to encourage the establishment of programs in urban areas and rural communities to make health services more accessible to the urban and rural Indian populations, respectively.

[CONTRACTS WITH URBAN AND RURAL INDIAN ORGANIZATIONS

[SEC. 502. The Secretary, acting through the Service, shall enter into contracts with urban Indian organizations and with rural Indian organizations to assist such organizations to establish and administer, in the urban centers or rural communities in which such organizations are situated, programs which meet the requirements set forth in sections 503 and 504.

[CONTRACT ELIGIBILITY

[SEC. 503. (a) The Secretary, acting through the Service, shall place such conditions as deemed necessary to effect the purpose of this title in any contract which the Secretary makes with any urban or rural Indian organization pursuant to this title. Such conditions shall include, but are not limited to requirements that the organization successfully undertake to—

[(1) determine the population of urban or rural Indians which are or could be recipients of health referral or care services;

[(2) identify all public and private health service resources within the urban center or rural community in which the organization is situated which are or may be available to urban Indians or rural Indians, respectively;

[(3) assist such health services resources in providing service to such urban or rural Indians;

[(4) assist such urban or rural Indians in becoming familiar with and utilizing such resources;

[(5) provide basic health education to such urban or rural Indians;

[(6) establish and implement manpower training programs to accomplish the referral and education tasks set forth in clauses (3) through (5) of this subsection;

[(7) identify gaps between unmet health needs of urban Indians or rural Indians and the resources available to meet such needs;

[(8) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban or rural Indians; and

[(9) where necessary, provide or contract for health care services to urban or rural Indians.

[(b) The Secretary, acting through the Service, shall by regulation prescribe the criteria for selecting urban Indian organizations and rural Indian organizations to enter into contracts pursuant to

this title. Such criteria shall, among other factors, take into consideration—

[(1) the extent of the unmet health care needs of urban Indians in the urban center or of rural Indians in the rural community invovled;

[(2) the size of the urban Indian population or the rural Indian community to receive assistance;

[(3) the relative accessibility of health care services to such population in such urban center of rural community;

[(4) the extent, if any, to which the activities set forth in subsection (a) would duplicate any previous or current public or private health services project in such urban center or rural community that was or is funded in a manner other than pursuant to this title;

[(5) the appropriateness and likely effectiveness of the activities set forth in subsection (a) in such urban center or rural community;

[(6) the existence of an urban Indian organization or a rural Indian organization capable of performing the activities set forth in subsection (a) and entering into a contract with the Secretary pursuant to this title; and

[(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

[OTHER CONTRACT REQUIREMENTS

[SEC. 504. (a) Contracts with urban Indian organizations or rural Indian organizations pursuant to this title shall be in accordance with all federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the act of August 24, 1935 (49 Stat. 793), as amended.

[(b) Payments under any contracts pursuant to this title may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.

[(c) Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization or a rural Indian organization, revise or amend any contract made by the Secretary with such organization under this title as necessary to carry out the purposes of this title: Provided, however, That whenever an urban Indian organization or a rural Indian organization requests retrocession of the Secretary for any contract entered into pursuant to this title, such retrocession shall become effective upon a date specified by the Secretary not more than one hundred and twenty days from the date of the request by the organization or at such later date as may be mutually agreed to by the Secretary and the organizaiton.

[(d) In connection with any contract made pursuant to this title, the Secretary may permit an urban Indian organization or a rural Indian organization to utilize, in carrying out such contract, existing facilities owned by the Federal Government within the Secre-

tary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities.

[(e) Contracts with urban or rural Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban or rural Indians of services and assistance under such contracts by such organizations.

[REPORTS AND RECORDS

[SEC. 505. For each fiscal year during which an urban Indian organization or a rural Indian organization receives or expends funds pursuant to a contract under this title, such organization shall submit to the Secretary a report including information gathered pursuant to section 503(a) (7) and (8), information on activities conducted by the organization pursuant to the contract, an accounting of the amounts and purposes for which Federal funds were expended, and such other information as the Secretary may request. The reports and records of the urban Indian organization or the rural Indian organization with respect to such contract shall be subject to audit by the Secretary and the Comptroller General of the United States.

[AUTHORIZATIONS

[SEC. 506. (a) There are authorized to be appropriated for contracts with urban Indian organizations under this title $18,750,000 for the fiscal year ending September 30, 1981, $21,500,000 for the fiscal year ending September 30, 1982, $24,725,000 for the fiscal year ending September 30, 1983, and $28,500,000 for the fiscal year ending September 30, 1984.

[(b) There are authorized to be appropriated for contracts with rural Indian organizations under this title $3,000,000 for the fiscal year ending September 30, 1981, $3,000,000 for the fiscal year ending September 30, 1982, $3,000,000 for the fiscal year ending September 30, 1983, and $3,000,000 for the fiscal year ending September 30, 1984.

[REVIEW OF PROGRAM

[SEC. 507. Not later than the date six months after September 30, 1983, the Secretary, acting through the Service and with the assistance of the urban and rural Indian organizations that have entered into contracts under this title, shall review the program established under this title and submit to the Congress an assessment thereof and recommendations for any further legislative efforts the Secretary deems necessary to meet the purpose of this title.]

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

PURPOSE

SEC. 501. The purpose of this title is to encourage the establishment of programs in urban centers to make health services more accessible to urban Indians.

CONTRACTS WITH URBAN INDIAN ORGANIZATIONS

SEC. 502. The Secretary, through the Service, shall enter into contracts with urban Indians organizations to assist such organizations to establish and administer, in the urban centers in which such organizations are situated, programs which meet the requirements set forth in this title. The Secretary, through the service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the secretary enters into with any urban Indian organization pursuant to this title.

CONTRACTS FOR THE PROVISION OF HEALTH CARE REFERRAL SERVICES

SEC. 503. (a) The Secretary, through the Service, shall enter into contracts with urban Indian organizations for the provision of health care or referral services for urban Indians residing in the urban centers in which such organizations are situated. Any such contract shall include requirements that the urban Indian organization successfully undertake to—

(1) determine the population of urban Indians residing in the urban center in which such organization is situated who are or could be recipients of health care or referral services;

(2) determine the current health status of urban Indians residing in such urban center;

(3) determine the current health care needs of urban Indians residing in such urban center;

(4) identify all public and private health services resources within such urban center which are or may be available to urban Indians;

(5) determine the use of public and private health services resources by the urban Indians residing in such urban center;

(6) assist such health services resources in providing services to urban Indians;

(7) assist urban Indians in becoming familiar with the utilizing such health services resources;

(8) provide basic health education to urban Indians;

(9) establish and implement manpower training programs to accomplish the referral and education tasks set forth in clauses (6) through (8) of this subsection;

(10) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;

(11) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

(12) where necessary, provide, or enter into contracts for the provision of health care services for urban Indian.

(b) The Secretary, through the Service, shall be regulation prescribe the criteria for selecting urban Indian organizations to enter into contracts under this section. Such criteria shall, among other factors, include—

(1) the extent of unmet health care needs of urban Indians in the urban center involved;

(2) the size of the urban Indian population in the urban center involved;

(3) the accessibility to, and utilization of, health care services (other than services provided under this title) by urban Indians in the urban center involved;

(4) the extent, if any, to which the activities set forth in subsection (a) would duplicate—

(A) any previous or current public or private health services project in an urban center that was or is funded in a manner other than pursuant to this title; or

(B) any project funded under this title;

(5) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary under this section;

(6) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

(7) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center; and

(8) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

CONTRACTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS

SEC. 504. (a) The Secretary, through the Service, may enter into contracts with urban Indian organizations situated in urban centers for which contracts have not been entered into under section 503. The purpose of a contract under this section shall be the determination of the matters described in subsection (b)(1) in order to assist the Secretary in assessing the health status and health care needs of urban Indians in the urban center involved and determining whether the Secretary should enter into a contract under section 503 with the urban Indian organization with which the Secretary has entered into a contract under this section.

(b) Any contract entered into by the Secretary under this section shall include requirements that—

(1) the urban Indian organization successfully undertake to—

(A) document the health care status and unmet health care needs of the urban Indians in the urban center involved;

(B) with respect to urban Indians in the urban center involved, determine the matters described in clauses (2), (3), (4), and (8) of section 503(b); and

(2) the urban Indian organization complete performance of the contract within one year after the date on which the Secretary and such organization enter into such contract.

(c) The Secretary may not renew any contract entered into under this section.

EVALUATIONS; CONTRACT RENEWALS

SEC. 505. (a) The Secretary, through the Service, shall develop procedures to evaluate compliance with, and performance of, contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

(b) The Secretary, through the Service, shall conduct an annual onsite evaluation of each urban Indian organization which has entered into a contract under section 503 for purposes of determining the compliance of such organization with, and evaluating the performance of such organization under, such contract.

(c) If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract, attempt to resolve with such organization the areas of noncompliance or unsatisfactory performance and modify such contract to prevent future occurrences of such noncompliance or unsatisfactory performance. If the Secretary determines that such noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract with such organization and is authorized to enter into a contract under section 503 with another urban Indian organization which is situated in the same urban center as the urban Indian organization whose contract is not renewed under this section.

(d) In determining whether to renew a contract with an urban Indian organization under section 503, or whether to enter into a contract with an urban Indian organization under section 503 which has completed performance of a contract under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and, in the case of a renewal of a contract under section 503, shall consider the results of the onsite evaluations conducted under subsection (b).

OTHER CONTRACT REQUIREMENTS

Sec. 506. (a) Contracts with urban Indian organizations pursuant to this title shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935, as amended.

(b) Payments under any contracts pursuant to this title may be made in advance or by the way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.

(c) Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

(d) In connection with any contract entered into pursuant to this title, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract, existing facilities owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities.

(e) Contracts with urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provisions to urban Indians of services and assistance under such contracts by such organizations.

REPORTS AND RECORDS

SEC. 507. (a) For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract under this title, such organization shall submit to the Secretary a quarterly report including—

(1) in the case of a contract under section 503, information gathered pursuant to clauses (10) and (11) of subsection (a) of such section;

(2) information on activities conducted by the organization pursuant to the contract;

(3) an accounting of the amounts and purposes for which Federal funds were expended; and

(4) such other information as the Secretary may request.

(b) The reports and records of the urban Indian organization with respect to a contract under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

(c) The Secretary shall allow as a cost of any contract entered into under section 503 the cost of an annual private audit conducted by a certified public accountant.

LIMITATION ON CONTRACT AUTHORITY

SEC. 508. The authority of the Secretary to enter into contracts under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

AUTHORIZATIONS

SEC. 509. There are authorized to be appropriated for contracts under this title—

(1) $9,800,000 for fiscal year 1986,
(2) $10,090,000 for fiscal year 1987
(3) $10,440,000 for fiscal year 1988, and
(4) $10,810,000 for fiscal year 1989.

TITLE VI—AMERICAN INDIAN SCHOOL OF MEDICINE; FEASIBILITY STUDY

[FEASIBILITY STUDY

[SEC. 601. The Secretary, in consultation with Indian tribes and appropriate Indian organizations, shall conduct a study to determine the need for, and the feasibility of, establishing a school of medicine to train Indians to provide health services for Indians. Within one year of the date of the enactment of this Act the Secretary shall complete such study and shall report to the Congress findings and recommendations based on such study.]

ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE

SEC. 601. (a) In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department of

Health and Human Services the Indian Health Service. The Indian Health Service shall be administered by a Director, who shall be appointed by the President, by and with the advice and consent of the Senate. The Director of the Indian Health Service shall report to the Secretary through the Assistant Secretary for Health, of the Department of Health and Human Services, and shall not report to, or be under the supervision of, any other officer or employee of such Department.

(b) The Indian Health Service shall be an agency within the Public Health Service of the Department of Health and Human Services, and shall not be an office, component, or unit of any other agency of the Department.

(c) The Secretary shall carry out through the Director of the Indian Health Service—

(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1985, carried out by or under the direction of the individual serving as Director of the Indian Health Service on such day;

(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and the provision and utilization of, health services for Indians; and

(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including (but not limited to) programs under—

(A) this Act;

(B) the Act of November 2, 1921 (25 U.S.C. 13);

(C) the Act of August 5, 1954 (68 Stat. 674);

(D) the Act of August 16, 1957 (71 Stat. 370); and

(E) the Indian Self-Determination and Education Assistance Act (Public Law 93–638).

(d)(1) Notwithstanding any other provision of law, the Secretary may not reorganize, alter, or discontinue the Indian Health Service or allocate or reallocate any function which this section specifies shall be performed by the Director of the Indian Health Service or by the Secretary of Health and Human Services through the Director of the Indian Health Service.

(2) Paragraph (1) shall not apply to any action taken by the Director of the Indian Health Service which the Director of the Indian Health Service determines to be appropriate.

(e)(1) The Director of the Indian Health Service shall have the authority—

(A) except to the extent provided in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

(C) to manage, expend, and obligate all funds appropriated for the Service.

(2) The provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), but not the provisions of section 2 of Public Law 96–135 (25 U.S.C. 472a), shall apply to personnel actions taken with respect to positions within the Service.

(3) The authority of the Director of the Indian Health Service to enter into contracts under this subsection shall be to such extent or in such amounts as are provided in appropriation Acts.

MANAGEMENT INFORMATION SYSTEM; ACCESS TO PATIENT'S RECORDS

SEC. 602. (a) The Secretary shall establish an automated management information system for the Service.

(b) the information system established under subsection (a) shall include—

(1) a cost accounting system,

(2) a patient care information system for each area served by the Service, and

(3) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service.

(c) Notwithstanding any other provisions of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

(d) The Secretary, by not later than September 30, 1988, shall provide—

(1) all tribes or tribal organizations providing health services in California under a contract with the Service under the Indian Self-Determination Act, and

(2) all urban Indian organizations providing health services in California under a contract with the Service under section 503 of this Act,

with automated management information systems which meet the management information needs of each such tribe or organization.

TITLE VII—MISCELLANEOUS

* * * * * * *

LEASES WITH INDIAN TRIBES

SEC. 704. *(a)* Notwithstanding any of the provision of law, the Secretary is authorized, in carrying out the purposes of this Act, to enter into leases with Indian tribes for periods not in excess of twenty years. Property leased by the Secretary from an Indian tribe may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe.

(b) The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold—

(1) title to;

(2) a leasehold interest in; or

(3) a beneficial interest in (where title is held by the United States in trust for the benefit of a tribe);

facilities used for the administration and delivery of health services by the Indian Health Service or by programs operated by tribes or tribal organizations to compensate such tribes or tribal organizations for costs associated with the use of such facilities for such purposes. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation

and maintenance expenses, and other expenses determined by regulation to be allowable.

* * * * * * *

[RESOURCE ALLOCATION PLAN

[SEC. 706. Within one year from the date of the enactment of this section, the Secretary shall submit to the Congress a resource allocation plan. Such plan shall explain the future allocation of services and funds among the service population of the Service and shall provide a schedule for reducing deficiencies in resources of tribes and nontribal specific entities.]

JUVENILE ALCOHOL AND DRUG ABUSE

SEC. 706. (a) Within ninety days of the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall enter into an agreement with the Secretary of the Interior and the Secretary of Education to coordinate the efforts of their Departments related to alcohol and drug abuse among Indian juveniles. The agreement shall provide for the identification and coordination of available resources and programs to combat Indian juvenile alcohol and drug abuse through prevention, education, counseling, and referral. The Secretary shall publish such agreement in the Federal Register within one hundred and twenty days of the date of enactment of the Indian Health Care Amendments of 1985.

(b) The Secretary, acting through the Service and in consultation and cooperation with the Secretary of the Interior and the Secretary of Education, shall develop a program to provide training in—

(1) preventive education;

(2) the identification of juvenile alcohol and drug abusers; and

(3) counseling techniques on juvenile alcohol and drug abuse.

Such training shall be provided to elementary and secondary teachers and counselors—

(A) in schools operated by the Bureau of Indian Affairs;

(B) in schools operated under contract with the Bureau of Indian Affairs; and

(C) in public schools on or near Indian reservations (including public schools in Oklahoma and Alaska with significant numbers of Indian students).

The Service may provide such training either directly or through contract with qualified private or public entities.

(c) The Secretary of the Interior, acting through the Bureau of Indian Affairs and in consultation with the Service, shall review existing literature and reports on juvenile alcohol and drug abuse, including studies and school curricula and any other material relevent to an understanding of the problem of juvenile alcohol and drug abuse, and shall make available the results of such review to the schools described in subsection (b).

(d) The Secretary shall establish an Office of Alcohol and Drug Abuse within the Service which shall be responsible for the administration of programs and authorities of the Service in the field of alcohol and drug abuse. The Office shall have assigned to it a

number of full-time equivalent positions which shall not be less than eight full-time equivalent positions in the Central Office of the Service and one full-time equivalent position in each Service area and Program Office.

(e) For the purpose of implementing subsection (b) there is authorized to be appropriated $1,500,000 for each of the fiscal years 1986, 1987, 1988, and 1989.

NUCLEAR RESOURCE DEVELOPMENT HEALTH HAZARDS

SEC. 707. [(a) The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian tribes and organizations, a study of the health hazards to Indian miners and Indians on or near Indian reservations and in Indian communities as a result of nuclear resource development. Such study shall include—

[(1) an evaluation of the nature and extent of nuclear resource development related health problems currently exhibited among Indians and the causes of such health problems;

[(2) an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities:

[(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear powerplant operation and construction, and nuclear waste disposal;

[(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the five years prior to the date of the enactment of this section that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

[(5) the efforts that have been made by Federal and State agencies and mining and milling companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such nuclear resource development.

[(b) Upon completion of such study the Secretary and the Service shall take into account the results of such study and develop a health care plan to address the health problems studies under subsection (a). The plan shall include—

[(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

[(2) preventive care for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation, or affected by other nuclear development activities that have had or could have a serious impact upon the health of such individuals; and

[(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear development activities, may experience health problems.]

(a) The Secretary, acting through the Service, shall enter into appropriate arrangements with the National Academy of Sciences to conduct a study of the health hazards to Indian miners and to Indians living on or near Indian reservations or in Indian communities which result from development of nuclear resources. Such study shall include—

(1) an evaluation of the nature and extent of nuclear resource development related health problems currently exhibited among Indians and the causes of such health problems;

(2) an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities;

(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal;

(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the ten-year period ending on the date of enactment of the Indian Health Care Amendments of 1985 that are directly or indirectly related to the activities, practices, and conditions affecting the health or safety of such Indians; and

(5) an evaluation of the efforts that have been made by Federal and State agencies and mining and milling companies to effectively carry out an education program for such Indians regarding the health and safety hazards of nuclear resource development.

To assist the Academy in conducting such study, the Secretary and the Secretary of the Interior shall furnish at the request of the Academy any information which the Academy deems necessary for the purpose of conducting the study. In addition, they shall cooperate with the Academy in obtaining information necessary to carry out the intent of the study.

(b) Upon completion of the study described in subsection (a), the Secretary, acting through the Service, shall develop, on the basis of the results of such study, a health care plan to address the health problems studied under subsection (a). The plan shall include—

(1) methods for diagnosing and treating Indians currently exhibiting nuclear resource development related health problems;

(2) preventive care for Indians who may be exposed to such health hazards as a result of nuclear resource development, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation, or otherwise affected by nuclear development activities that have had or could have a serious impact upon the health of such individuals; and

(3) a program of education for Indians who, by reason of their work or geographic proximity to nuclear development activities, may experience health problems.

(c) The Secretary and the Service shall submit to Congress the study prepared under subsection (a) [no later than the date eighteen months after the date of enactment of this section.] *no later than the date which is 18 months after the date of enactment of the*

Indian Health Care Amendments of 1985. The health care plan prepared under subsection (b) shall be submitted in a report no later than the date one year after the date that the study prepared under subsection (a) is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the service to address such health problems.

* * * * * * *

[(f) There is authorized to be appropriated $300,000 to carry out the study as provided in subsection (a), such amount to be expended by the date eighteen months after the date of the enactment of this section.]

(f) There are authorized to be appropriated $750,000 for the purpose of conducting the study described in subsection (a). Such funds shall remain available for expenditure until the date which is eighteen months after the date such funds are appropriated.

ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

SEC. 708. (a) For the fiscal years beginning with the fiscal year ending September 30, 1982, and ending with the fiscal year ending September 30, [1984], *1989,* the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to [Indians in such State.] *members of Federally recognized Indian tribes of Arizona.*

(b) The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

[(c) There are authorized to be appropriated to carry out this section $2,000,000 for the fiscal year ending September 30, 1982, $2,000,000 for the fiscal year ending September 30, 1983, and $2,000,000 for the fiscal year ending September 30, 1984.]

(c) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $7,700,000 for fiscal year 1986,
(2) $8,242,000 for fiscal year 1987,
(3) $8,819,800 for fiscal year 1988, and
(4) $8,434,600 for fiscal year 1989.

[CALIFORNIA FORMER FEDERALLY RECOGNIZED TRIBES

[SEC. 709. Indians in the State of California who are members or descendants of members of former federally recognized tribes of the State of California shall be eligible for services from the Service in the fiscal years beginning with the fiscal year ending September 30, 1982, and ending with the fiscal year ending September 30, 1984.]

ELIGIBILITY OF CALIFORNIA INDIANS

SEC. 709. The following California Indians shall be eligible for care from the Service:

(1) Any member of a Federally recognized Indian tribe.

(2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant—

(A) is living in California,

(B) is a member of the Indian community served by a local program of the Service, and

(C) is regarded as an Indian by the community in which such descendant lives.

(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

Paragraph (4) shall not apply after September 30, 1988.

[PERSONNEL CEILINGS DEMONSTRATION PROJECT

[SEC. 710. (a) In order to determine whether the Service can be better managed through fiscal controls without personnel ceilings, the Service shall, in conjunction with the Office of Personnel Management and the Secretary, conduct a demonstration project in which certain personnel ceilings in the Service are lifted. Such demonstration project shall be conducted in two of the Indian Health Service areas and shall be closely monitored by the Service.

[(b) Not later than the date 2 years after the date of the enactment of this section, the Service shall submit a report to Congress regarding the demonstration project carried out under subsection (a). Such report shall include a discussion of whether the lifting of personnel ceilings would improve the Service's ability to deliver services, what potential negative impact the lifting of personnel ceilings might have on the control of Federal employment, and a determination as to whether the lifting of personnel ceilings should be expanded to the entire Service.]

CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

SEC. 710. The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, and Santa Clara, shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State.

CONTRACT HEALTH FACILITIES

SEC. 711. (a) The Indian Health Service shall provide funds for health care programs and facilities operated by tribes and tribal organizations under contracts with the Indian Health Service under the Indian Self-Determination Act—

(1) for the maintenance and repair of clinics owned or leased by such tribes or tribal organizations,

(2) for employee training,

(3) for cost-of-living increases for empoyees, and

(4) for any other expenses relating to the provision of health services,

on the same basis as such funds are provided to programs and facilities operated directly by the Indian Health Service.

(b) In the case of eligible California Indians as defined by section 709 who are not members of Indian tribes or eligible for membership in such tribes, the Secretary may not enter into a contract to provide health services to such Indians under section 103 of the Indian Self-Determination Act if 51 per centum of the adult population of such Indians object prior to the award of such contract through any legally established organization of Indians representative of such Indians, in which case the Secretary, acting through the Service, shall make alternate arrangements for the delivery of health care services to such Indians. In making such alternative arrangements for such Indians, the Service may—

(1) provide services directly to some or all of such Indians through its own facilities,

(2) purchase services for some or all of such Indians on a contract basis,

(3) contract with a qualified organization representing some or all of such Indians for the provision of services under the terms of the third proviso of the first paragraph under the heading "Secretary" in the division relating to general provisions of the Act of April 30, 1908 (35 Stat. 71, chapter 153; 25 U.S.C. 47), popularly known as the Buy Indian Act, or

(4) make other effective arrangements for the delivery of health care services to such Indians.

(c) Nothing in this section shall be construed to restrict or interfere with the right of any Indian tribe to contract for health services on behalf of its own members.

NATIONAL HEALTH SERVICE CORPS

Sec. 712. (a) The Secretary of Health and Human Services shall not—

(1) remove a member of the National Health Service Corps from a health facility operated by the Indian Health Service or by a tribe or tribal organization under contract with the Indian Health Service under the Indian Self-Determination Act; or

(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from such member will experience no reduction in services.

(b) The amendment made by subsection (a) of this section shall take effect as of January 1, 1984.

SERVICE TO INELIGIBLE PERSONS

Sec. 713. (a)(1) The Secretary, acting through the Service, may provide or authorize the provision of medical care, treatment, or benefits by the Service to persons who are not otherwise eligible for such services in health facilities maintained by the Service or contracted under the Indian Self-Determination Act (Public Law 93–638) or through contract health care services, subject to the limitations of this section.

(2) Persons eighteen years of age or under who are the natural or adopted children (including foster- and step-children), legal wards,

or orphans of an eligible Indian person and who are not otherwise eligible for the medical care, treatment, or benefits of the Service shall be eligible for all such services on the same basis and subject to the same rules as apply to eligible Indians until their nineteenth birthday. The existing potential medical needs of such persons shall be taken into consideration by the Service in determining the need for, or the allocation of, its health resources. Any such person who has been determined to be legally incompetent prior to their nineteenth birthday shall remain eligible for such services until one year after the date such disability has been removed.

(3) Non-Indian spouses of eligible Indians or spouses of Indian descent who are not otherwise eligible for the medical care, treatment, or benefits of the Service shall not be eligible for the medical care, treatment, or benefits of the Service unless they are made eligible, as a class, by an appropriate resolution of the governing body of the relevant Indian tribe. The medical needs of persons made eligible under this subsection shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

(b)(1)(A) At the request of the Indian tribe or tribes included within the service area of any service unit of the Service, the Secretary may authorize the medical care and treatment of otherwise ineligible persons residing within such service area in health facilities maintained and operated by the Service.

(B) Persons receiving medical care and treatment under this subsection shall be liable for the payment for such services under a fee schedule adopted by the Secretary which, in the judgment of the Secretary, shall result in reimbursement in an amount not less than the actual cost of providing the service. Fees collected under this subsection, including medicare or medicaid reimbursements under titles XVIII and XIX of the Social Security Act, shall be credited to the account of the facility providing the service and shall be used solely for the provision of health services within that facility.

(2)(A) Except as provided in subparagraph (B), where the governing body of an Indian tribe or, in the case of a multitribal service area, any Indian tribe revokes its concurrence to the provision of services under paragraph (1)(A), the Secretary's authority to provide such service shall terminate at the end of the fiscal year following the fiscal year in which such revocation was adopted.

(B) In California, in the case of a multitribal service area, unless 51 per centum or more of the Indian tribes in the service area revoke their concurrence to the provision of services under paragraph (1)(A), the authority to provide such service shall not be affected.

(3)(A) In the case of health facilities operated directly by the Service, such medical care and treatment may be provided under this subsection only where the Secretary and the affected tribe or tribes have jointly determined that—

(i) the provision of such service will not result in a denial or diminution of services to eligible Indian persons; and

(ii) there is no reasonable alternative health facility or service, within or without the service unit area, available to meet the medical needs of such person.

(B) In the case of health facilities operated under contract under the Indian Self-Determination Act, the governing body of the Indian

tribe or tribal organzation providing health services under a contract with the Service under the Indian Self-Determination Act is authorized to determine the eligibility for such services of persons who are not otherwise eligible for such services. Such determination shall be in accordance with the requirements of this section.

(4) The Service may continue to provide medical care, treatment, and benefit to persons not provided service under subsection (a) or (b) to achieve stability in a medical emergency, to prevent the spread of a communicable disease or otherwise deal with a public health hazard; to provide care to non-Indian women pregnant with an eligible Indian's child for the duration for the pregnancy through post partum, or to immediate family members of an eligible person where such care is directly related to the treatment of the eligible person.

(5) Hospital privilege in health facilities operated and maintained by the Service or operated under contract under the Indian Self-Determination Act may be extended to non-Service health care practitioners. Such non-Service health care practitioners shall not be regarded as employees of the Federal Government for purposes of the provisions of title 28 of the United States Code relating to Federal tort claims even if providing services to eligible persons as a part of the condition under which privileges are extended.

RESTRICTIONS ON THE USE OF INDIAN HEALTH SERVICE APPROPRIATIONS

SEC. 714. (a) Unless otherwise specifically provided, any restriction placed on the use of appropriations for Indian health services shall not be interpreted—

(1) to apply to the use of funds other than such appropriated funds by an entity with a contract with the Indian Health Service;

(2) to prohibit the support of litigation with such other funds; or

(3) to prohibit the promotion of public support for or opposition to any legislative proposal with such other funds.

(b) The Service may not offset or limit the amount of funds obligated to any entity under contract with the Service because of the use of funds, other than funds appropriated to the Indian Health Service, by such entity for the purposes described in paragraphs (1) through (3) of subsection (a).

INFANT AND MATERNAL MORTALITY

SEC. 715. (a) Not later than January 1, 1986, the Secretary shall develop and begin implementation of a plan to achieve the following objectives by January 1, 1991:

(1) Reduction of the rate of Indian infant mortality in each Area Office of the Service to twelve deaths per one thousand live births or to that of the United States population, whichever is lower.

(2) Reduction of the rate of maternal mortality in each Area Office of the Service to five deaths per one hundred thousand live births or to that of the United States population, whichever is lower.

(b) The Secretary shall report to Congress on January 1 of each year beginning after fiscal year 1986 on the progress that has been made toward achieving the objectives described in subsection (a).

CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA

SEC. 716. The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

INDIAN HEALTH SERVICE AND VETERANS' ADMINISTRATION HEALTH FACILITIES AND SERVICES SHARING

SEC. 717. (a) The Secretary shall examine the feasibility of entering into an arrangement for the sharing of medical facilities and services between the Indian Health Service and the Veterans' Administration and shall, in accordance with subsection (b), prepare a report on the feasibility of such an arrangement and submit such report to the Congress not later than September 30, 1986.

(b) The Secretary may not make any recommendation under subsection (a) nor take any action under subchapter IV of part VI of title 38, United States Code which would impair—

(1) the priority access of any Indian to health care services provided through the Indian Health Service;

(2) the quality of health care services provided to any Indian through the Health Service;

(3) the priority access of any veteran to health care services provided by the Veterans' Administration;

(4) the quality of health care services provided to any veteran by the Veterans' Administration;

(5) the eligibility of any Indian person to receive health services through the Indian Health Service; or

(6) the eligibility of any Indian person who is a Veteran, to receive health services through the Veterans' Administration.

NAVAJO ALCOHOL REHABILITATION DEMONSTRATION PROGRAM

SEC. 718. (a) The Secretary shall make grants to the Navajo tribe to establish a demonstration program in the city of Gallup, New Mexico, to rehabilitate adult Navajo Indians suffering from alcoholism or alcohol abuse.

(b) The Secretary, acting through the National Institute on Alcohol Abuse and Alcoholism, shall evaluate the program established under subsection (a) and submit a report on such evaluation to the appropriate Committees of Congress by January 1, 1989.

(c)(1) There is authorized to be appropriated for the purposes of this section $400,000 for each of the fiscal years 1986, 1987, and 1988.

(2) Not more than 10 percent of the funds approriated under paragraph (1) for any fiscal year may be used for administrative purposes.

STUDY OF HEALTH CARE NEEDS OF NATIVE HAWAIIANS AND OTHER NATIVE PACIFIC ISLANDERS

SEC. 719. (a)(1) The Secretary shall conduct a study of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders.

(2) In conducting the study required under paragraph (1), the Secretary shall consult with the Commissioner of the Administration for Native Americans, the Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, the Director of the Indian Health Service, leaders in the field of health care, and representatives of Native Hawaiians and other Native American Pacific Islanders.

(b) By no later than the date that is 1 year after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress a report on the study conducted under subsection (a). Such report shall include—

(1) an assessment of the access of, and barriers to, native Hawaiians and other Native American Pacific Islanders in receiving physical and mental health care services,

(2) an assessment of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders, and

(3) specific recommendations for the development of a national strategy to address such needs.

SOCIAL SECURITY ACT

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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INDIAN HEALTH SERVICE FACILITIES

SEC. 1911. (a) A facility of the Indian Health Service (including a hospital, intermediate care facility, [or] skilled nursing facility, *or any other type of facility which provides services of a type otherwise covered under the State plan*), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title.

(b) Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, intermediate care facility, [or] skilled nursing facility, *or any other type of facility which provides services of a type otherwise covered under the plan*) which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such con-

ditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its acutal compliance with such conditions and requirements, during the first twelve months after the month in which such plan is submitted.

(c) The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan.

(d) Notwithstanding any other provision of law, payments to which any facility of the Indian Health Service (including a hospital, intermediate care facility, skilled nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) is entitled under a State plan approved under this title by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. In making payments from such fund, the Secretary shall ensure that each service unit of the Indian Health Service receives at least 50 percent of the amounts to which the facilities of the Indian Health Service, for which such service unit makes collections, are entitled by reason of this section, if such amount is necessary for the purpose of making improvements in such facilities in order to achieve compliance with the conditions and requirements of this title. This subsection shall cease to apply when the Secretary determines and certifies that substantialy all of the health facilities of such Service in the United States are in compliance with such conditions and requirements.

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PUBLIC HEALTH SERVICE ACT

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

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PART D—PRIMARY HEALTH CARE

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Subpart II—National Health Service Corps Program

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[INDIAN HEALTH SCHOLARSHIP PROGRAM

[SEC. 338G. (a) In addition to the sums authorized to be appropriated under section 756(a) to carry out the Scholarship Program, there are authorized to be appropriated $5,450,000 for the fiscal year ending September 30, 1978, $6,300,000 for the fiscal year

ending September 30, 1979, $7,200,000 for the fiscal year ending September 30, 1980, $9,000,000 for the fiscal year ending September 30, 1981, $10,300,000 for the fiscal year ending September 30, 1982, $11,800,000 for the fiscal year ending September 30 1983, and $13,600,000 for the fiscal year ending September 30 1984, to provide scholarships under the Scholarship Program to provide physicians, osteopaths, dentists, veterinarians, nurses, optometrists, podiatrists, pharmacists, clinical psychologists, public health personnel, and allied health professionals to provide services to Indians. Such scholarships shall be designated "Indian Health Scholarships" and shall be made in accordance with this subpart, except as provided in subsection (b).

[(b)(1) The Secretary, acting through the Indian Health Service, shall determine the individuals who shall receive the Indian Health Scholarships, shall accord priority to applicants who are Indians, and shall determine the distribution of the scholarships on the basis of the relative needs of Indians for additional services by specific health professions.

[(2) The active duty service obligation prescribed in the written contract entered into under this subpart shall be met by the recipient of an Indian Health Scholarship by service in the Indian Health Service, in a program assisted under title V of the Indian Health Care Improvement Act, or in the private practice of the applicable profession if, as determined by the Secretary in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

[(c) For purposes of this section, the term "Indians" has the same meaning given that term by subsection (c) of section 4 of the Indian Health Care Improvement Act and includes individuals described in clauses (1) through (4) of that subsection.]

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MINORITY VIEWS ON H.R. 1426—INDIAN HEALTH CARE AMENDMENTS OF 1985

Although the Indian Health Care Improvement Act is only one of several laws that authorize Federal funds to be expended by the Indian Health Service, we believe that each bill that affects the Service should be acted upon in a fiscally responsible manner.

In this regard, we are particularly concerned about the inclusion in H.R. 1426 of a number of new programs not heretofore authorized under the Indian Health Care Improvement Act. One major new initiative authorized in H.R. 1426 is the establishment of an Indian Health Catastrophic Health Emergency Fund to meet the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses. This new authority is inappropriate and unnecessary. The Indian Health Service currently has the authority to shift funds from one service delivery site to another when need dictates. The establishment of a separate fund will simply make the distribution of funds to sites that have experienced disasters or catastrophic illnesses more administratively burdensome.

We believe that a number of new initiatives authorized in Title VII, including those for Juvenile Alcohol and Drug Abuse Services, a Nuclear Resource Development Health Hazards Study, Arizona Contract Health Service Delivery Area designation, and a Navajo Alcohol Rehabilitation Demonstration Program, may be meritorious, but that the Nation's current deficit prohibits us from supporting them. We believe that the purpose of the Indian Health Service is to provide health services to Native Americans who live on or near reservations in those instances when services cannot be obtained from other sources. Programs that are not consistent with that mission should not be authorized.

Finally, we do not believe that the elevation of the Indian Health Service (IHS) from a bureau within the Health Resources and Services Administration (HRSA) to a separate agency within the Public Health Service is sound public policy. We believe that this compromise is preferable to the provision in the original bill that elevated the IHS to a level directly below the Secretary of Health and Human Services, but feel strongly that IHS's interests are best served by keeping it as a part of HRSA. As the agency of the Department of Health and Human Services responsible for the delivery of health services to populations that are not adequately served by the private sector, HRSA can coordinate the effective utilization

of resources such as the National Health Service Corps at Indian Health sites.

James T. Broyhill.
Norman F. Lent.
Ed Madigan.
Matt Rinaldo.
Bill Dannemeyer.
Thomas J. Tauke.
Don Ritter.
Dan Coats.
Tom Bliley.
Jack Fields.
Michael G. Oxley.
Howard C. Nielson.
Mike Bilirakis.
Dan Schaefer.
Carlos J. Moorhead.

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